ALASKA LEGISLATURE COMMITTEE FILES 1993-1994 8672

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than the life against loss due to liability to third parties or for the benefit of third parties.

UNDERWRITING: The selection process through which an insurer determines which of the risks offered to it should be accepted, and, if so, on what terms and for what amounts. Three purposes of underwriting: 1) to secure a safe distribution of risks; 2) to secure a profitable distribution of risks; and 3) to maintain equity among individual policyholders.

UNDERWRITING PROFIT: That portion of the earnings of an insurance company that comes from the function of underwriting. It excludes the earnings from investments either in the form of income from securities or sale of securities at a profit. The remainder is found by deducting incurred losses and expenses from earned premiums.

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Assessing the Effects of Tort Reforms

Stephen J. Carroll
With Nicholas Pace

1987

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Alaska State Legislature

Legislative Research Agency

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March 17, 1992

MEMORANDUM

TO: Representative Mark Boyer

FROM: Maureen Weeks MW
Legislative Analyst

RE: State Approaches to Medical Malpractice
Research Request 91.222

You asked for an analysis of medical liability issues in Alaska today. You also asked about alternatives for compensating victims of medical negligence. To answer your question, part one of this report, "Medical Liability in Alaska," discusses medical malpractice claims, payments and premiums in Alaska and how they affect physician practices and incomes. It includes plaintiff and defense lawyers' suggestions for change. Part two discusses alternatives to tort reform. The appendix contains a partial list of medical malpractice litigation in Alaska since 1977. Major findings of this report are summarized below. A table of contents follows.

In this report, the word "physician" is shorthand for all practitioners who might be named in malpractice claims. They include nurse midwives, nurses, physician assistants, dentists, psychologists and many other actors within the health care system.

SUMMARY

Two landmark studies show that 1 percent of all hospital patients are injured by negligent medical care (1 in 25 patients are injured by medical care and 1 in 4 of these are injured by negligence). The more recent of the two studies indicates that negligence is a factor in half of all deaths resulting from medical injury, that 7 to 8 times as many patients are injured as file claims, that only 1 to 2 percent of patients who suffer a negligent injury file a malpractice claim and that approximately 85 percent of claims are filed in cases in which medical records show neither negligence nor injury (as defined by physician reviewers). In Alaska, these estimates would represent about:

- 1,480 medical injuries in hospitals yearly;
- 400 medical injuries caused by negligence in hospitals yearly;

- 100 deaths caused at least in part by medical negligence in hospitals yearly; and

- roughly 6 hospital patients with negligent injuries (as defined by the study's panel of physician reviewers) who file medical malpractice claims yearly.

Like other states, Alaska twice in the past has found itself in a medical liability emergency. Twice, Alaska legislators have modified state tort laws in the hopes of avoiding another "crisis." Today, however, it is difficult or impossible to obtain the historical data needed to measure the effectiveness of these past tort reforms. Malpractice insurers hesitate to share internal data showing trends in claims by patients or payments made on behalf of physicians or hospitals, and no state law requires this disclosure. Available records indicate that Alaska patients filed an average of:

- more than seven malpractice claims a month between 1983 and 1988; and

- two to three malpractice lawsuits a month between 1978 and 1989.

Insurance executives say the number of Alaska medical malpractice claims filed with liability insurers may have dropped since 1985.

In 1983, an observer noted that there had never been an award or settlement in excess of $500,000 in a medical malpractice action in Alaska. That is no longer the case. The years 1988 and 1989 alone saw several multi-million dollar verdicts and settlements in this state. One lawyer says the typical settlement, which is usually secret, is "far higher" than the typical verdict, which is usually public.

- The largest malpractice award in Alaska was a court verdict of more than $8 million against a federal hospital in 1989. In addition, insurance companies record roughly half a dozen payments of $2 million or more against Alaska physicians or hospitals for 1988 and 1989 alone.

- Records available to the public show that insurance companies since 1976 have paid $34 million to satisfy Alaska malpractice claims, but the actual number is higher.

Meanwhile, the cost of medical malpractice premiums for physicians rose rapidly in Alaska in the 1980s but has stabilized, ranging from $4,500 to $90,000 per year, depending on specialty and level of coverage. Alaska physicians and hospitals have paid an average of nearly $10.5 million a year for medical malpractice premiums since 1984. Studies show that physicians quickly pass the cost of malpractice insurance premiums on to their patients. Real net physician income is holding steady nationwide and one of six U.S. physicians nets at least $250,000 annually. No study of physician income in Alaska

exists. Between 15 and 20 percent of Alaska physicians, as well as some hospitals, carry no liability insurance.

Obstetricians are at high risk for costly medical malpractice claims. A state study shows that fewer than half of Alaska physicians who are trained to deliver babies provided obstetric care in 1988. Physicians claim they practice "defensive" medicine to avoid the threat of lawsuits. Some lawyers suggest that recent state efforts to cure medical liability problems are ineffective and expensive. Among their proposals:

- Regulate insurers, modify prejudgment interest, protect physicians who provide emergency care, subsidize insurance premiums of rural physicians who deliver babies, gather historical data, transfer high-risk mothers to urban centers before the baby is due, include hospitals in statutes which since 1990 have required physicians to report malpractice payments, fine physicians who do not report questionable practices by colleagues, guarantee anonymity and immunity to whistle-blowing nurses, do away with the expert advisory panel, set up universal health insurance and try alternatives to the tort system.

This report concludes that the tort system in Alaska does not justly compensate the estimated 400 Alaskans who are injured by negligent hospital care each year. Evidence also shows that the system does not deter negligent medical care in Alaska; does not hold negligent Alaska physicians accountable; does not force public disclosure of dangerous practices; and does not provide a judicial forum where responsibility can be established.

Part two of this report summarizes selected alternatives to the tort system contemplated and underway in other states. See the table of contents for the list of alternatives to tort reform contemplated or underway in other states and described in part two.

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APPENDIX

A Selected Medical Malpractice Verdicts in Alaska

B The History of Medical Malpractice Litigation in Alaska

C List of Alaska Medical Malpractice Claims 1977-1989

D List of Anchorage Medical Malpractice Lawsuits 1988-1992

MEDICAL LIABILITY IN ALASKA

BACKGROUND

Currently, about 600 private physicians and more than 200 public physicians practice medicine in Alaska. Three major medical malpractice insurers cover most private physicians, hospitals and dentists in Alaska. The companies are:

- Norcal Mutual Insurance Company, which acquired Medical Indemnity Corporation of Alaska (MICA, a primary medical malpractice insurer created by the Alaska legislature) in 1990. Today Norcal covers about 240 Alaska physicians.
- Medical Indemnity Exchange of California (MIEC). Today MIEC covers about 200 Alaska physicians.
- CNA Insurance Companies. This company covers most Alaska dentists and some physicians.

About 5 percent of physicians nationwide and an estimated 15 to 20 percent of Alaska physicians have no malpractice liability insurance. Several rural Alaska hospitals are not insured or are self-insured.[1]

THE EXTENT OF INJURY AND NEGLIGENCE: U.S. AND ALASKA

Negligence and Injury

A recent Harvard study indicates that 1 percent of all hospitalized patients experience negligent injury (roughly 1 in 25 hospital patients are injured by medical care, and 1 in 4 of these are injured by negligence). Negligence is a factor in half of all deaths resulting from medical injury.[2]

- Similar observations were published in 1984 by Patricia Danzon, now of the Wharton School at the University of Pennsylvania. In that study, 1 of every 126 California hospital patients in the

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[1]Mary Pierce, testimony before the House Labor and Commerce Committee, February 20, 1990 (for the 15 percent figure); Ron Neupauer, underwriting manager, Medical Insurance Exchange of California, telephone conversation, January 14, 1992 (for the 5 percent and 20 percent figures); and David Rogers, "Almost Everything You Ever Wanted to Know About Liability Issues," report to Liability Insurance Task Force, Alaska State House, 1990, p. 3.

[2]The Harvard Medical Practice Study, Patients, *Doctors and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation*, Harvard University, 1990, pp. 4 and 11-1.

mid-1970s were injured by negligent medical care. The Harvard Medical Practice Study, published in 1990, found 1 in every 108 New York state hospital patients were injured by negligent medical care.[3] See Table 1.

- The Harvard and Danzon studies both show that negligent injuries result in greater disability than do non-negligent injuries.

TABLE 1
Negligence and Medical Injuries During Hospitalization
Studies by P. Danzon (1974) and Harvard University (1984)

Study	Percent of Medical Injury During Hospitalization (A)	Percent of Negligence During Medical Injury (B)	Percent of Negligent Medical Injury During Hospitalization (C)	Rate* (D)
Danzon (California)	4.6	17.0	.79	1:126
Harvard (New York)	3.7	27.6	.93	1:108

* Rate is defined as number of injuries per number of admissions (Injuries : Admissions)

Source: Patricia M. Danzon, Medical Malpractice: Theory, Evidence and Public Policy, Harvard University Press, 1985, Chapter 2 (California Study); and Harvard Medical Practice Study, Patients, Doctors and Lawyers: Medical Injury, Malpractice Litigation and Patient Compensation in New York, 1990, Chapter 6 (New York Study). (91.222TA)

Negligence and Malpractice Claims

The Harvard study finds that the more severe the patient's medical injury, the more likely it was caused by negligence. Negligence was a factor in half of all deaths from medical injury. Nevertheless, negligently injured patients are unlikely to file medical malpractice claims. The study further finds that more than eight of ten medical records of those who file claims show "no evidence of negligence or even injury."

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[3]Patricia Danzon, *Medical Malpractice: Theory, Evidence and Public Policy*, Harvard University Press, 1985, Chapter 2; and The Harvard Medical Practice Study, *Patients, Doctors and Lawyers: Medical Injury, Malpractice Litigation and Patient Compensation in New York*, Harvard University, 1990, Chapter 6.

In the Harvard study:

- Fewer than 2 percent of negligently injured hospital patients filed malpractice claims (HMPS p. 7-31).

- Eight times as many hospital patients suffered a negligent injury as filed a formal malpractice claim (HMPS p. 6)[4]

- Approximately 85 percent of claims were filed in cases in which a physician review panel found neither negligence nor injury (HMPS p. 6 and author Troyen Brennan, personal communication). The definition does not include pain and suffering.[5]

The correlation between negligence and severity of injury (HMPS p. 6-22) is shown on Table 2, Column E. No analyst has ventured to explain why, despite this correlation, most negligently injured patients refrain from filing malpractice claims.[6] One Alaska lawyer-expert in medical malpractice says medical malpractice cases slip through the cracks because lawyers "are very careful about taking medical malpractice cases." They take only the very best, he says, and many deserving claims go no farther than the lawyer's desk.

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[4]Formal claims do not include "observation" or "potential" claims opened by carriers.

[5]Dr. Rodman Wilson of Anchorage, who has followed Alaska's pre-trial review process from its beginning, says physician reviewers on expert advisory panels have no difficulty identifying cases involving "bad medicine" (comments at Health Resources and Access Task Force, Alaska State Legislature, March 14, 1992).

[6]A glimpse into the motivation for filing claims is found in a 1983 Alaska Supreme Court opinion. The claimant testified she was slow to file a malpractice lawsuit after an overdose of lidocaine which caused a cardiac arrest in the hospital because:

> ". . . it seemed like you had to sue for so horrible much, and it was--I didn't want anybody's hide, I wanted just compensation--that didn't seem to be feasible at the time, but as long as he was not on the staff and able to affect anyone else adversely, I felt that was sufficient." *Sharrow v. Archer* 658 P.2d 1331 (Alaska 1983)

TABLE 2
Medical Injuries and Negligence
Applying Harvard Medical Practice Study (HMPS) to Alaska

Disability	Portion and Number of Injuries Resulting in Disability		Portion and Number of Negligent Injuries Resulting in Disability		
	(A) Injuries HMPS (Percent)	(B) Injuries Alaska (1) (Number)	(C) Negligent Injuries HMPS (Percent)	(D) Negligent Injuries Alaska (2) (Number)	(E) Rate of Injuries In Category Due to Negligence
Minimal Impairment (Recover 1 mo.)	56.8	841	45.7	187	22.2
Moderate Impairment (Recover 1-6 Mos.)	13.7	203	12.1	50	24.4
Moderate Impairment (Recover > 6 Mos.)	2.8	41	3	12	29.6
Permanent Impairment (< 50% disability)	3.9	58	3.2	13	22.8
Permanent Impairment (>50% disability)	2.6	38	3.2	13	34.3
Death	13.6	201	25.4	103	51.3
Cannot Judge Disability	6.6	98	7.3	30	30.7
Total	100%	1480	100%	408	27.6

(1) Column A x 1,480 Alaska medical injuries [1,480 = 40,000 hospitalizations x 3.7% injury rate]
(2) Column C x 408 Alaska negligent medical injuries

Source: Harvard Medical Practice Study, 1990, extrapolating to Alaska, assuming 40,000 hospitalizations per year.

(91.222TB)

Applying the Harvard Study to Alaska

If the trends in the Harvard study were to hold true in Alaska, every year about 400 Alaska hospital patients would be injured by negligence and about 100 of these would die, at least in part from their negligent injuries. Only a fraction of injured patients would file claims.

The Harvard study trends applied to Alaska would represent per year:[7]

- about 1,480 medical injuries in Alaska hospitals;
- about 408 medical injuries from negligence in Alaska hospitals;

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[7]In an interview for this report, Dr. Troyen Brennan, assistant professor at Harvard and an author of the study, said no one has challenged the methodology used in the report and "you can take the numbers to the bank" (personal communication, February 3, 1991). Dr. Ross Brudenell, chair of the Alaska State Medical Association's medico-legal committee, objects that the study does not define patient injury but agrees with the conclusion that 1 percent of hospital patients experience negligent injury (personal communication, February 13, 1992).

- about 103 deaths from negligent medical injuries in Alaska hospitals; and

- about 50 Alaska hospital patients would file malpractice claims, but only 6 patients with injuries deemed negligent by the Harvard physician review panel would file claims

Table 3 shows the steps taken to reach these conclusions.[8]

TABLE 3
Harvard Medical Practice Study (HMPS) Applied to Alaska

Percent in HMPS	X	No. in Alaska	Disability Category	=	Number of Alaska Hospital Patients	
3.7%	X	40,000	Alaska hospitalizations	=	1,480	medical injuries
27.6%	X	1,480	Alaska negligent medical injuries	=	408	negligent medical injuries (1)
13.6%	X	1,480	Alaska negligent medical injuries	=	201	deaths from medical injuries
51.0%	X	201	Alaska deaths from medical injuries	=	103	deaths from negligent medical injuries
1.5%	X	408	Alaska negligent medical injuries	=	6	patients with negligent medical injuries file claims (1)

(1) Negligent medical injuries as defined by teams of physician reviewers; does not include pain and suffering

Source: Harvard Medical Practice Study and Alaska Department of Health and Social Services

(91.222TC)

Common Medical Malpractice Targets

Some specialties (surgery, anesthesiology and obstetrics) are more likely than others to be targets of malpractice claims. No one suggests that these specialists are more negligent than other physicians. Rather, the procedures they perform are more hazardous, the errors they make are more detectable, the patients they treat are more severely injured, and the technology they use results in highly visible injuries.

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[8]Based on 40,000 hospital patients per year. This is a conservative estimate. Some 40,483 patients were discharged from 20 hospitals in 1990. Five hospitals did not report: Mt. Edgecumbe Hospital, Yukon-Kuskokwim Delta Hospital, Elmendorf Air Force Base Hospital, Barrow PHS/ANH, and Kotzebue PHS/ANH. Yolanda Lozana and Bradley Whistler, *1990 Alaska Hospital Survey*, Alaska Department of Health and Social Services, April 1, 1991, Table 2.10, "1990 Alaska Hospital Survey, Acute Care Facilities, Discharges by Primary Diagnosis," pp. 63-87.

- One recent study shows that certain types of physicians are less likely targets. They are physicians who are older, female or not board-certified. Author Frank Sloan of Vanderbilt University hypothesizes that older physicians may provide fewer technologically sophisticated and risky services; that female physicians may have a patient-physician style less conducive to claims; and that nonboard-certified physicians may take fewer complex procedures.[9]

Alaska Targets: Orthopedists, Family Practitioners and Surgeons

One small study shows that between 1977 and 1981, Alaskans were more likely to file claims against orthopedists, family practitioners and surgeons. Claims were likely to allege a problem with surgery or a missed diagnosis. Another study shows breast cancer as the most common missed diagnosis. A small number of Alaska claims account for a high percent of total payments. One insurance executive says most physicians targeted in malpractice claims are the kind ". . . you and I would send our families to. They do the heroic work in high-risk specialties and that is the kind of work that is sued."[10]

- An unpublished 1983 study of Alaska medical malpractice lawsuits heard by state expert advisory panels shows that between 1977 and 1981, one in seven malpractice lawsuits were filed against an orthopedist, family practitioner or surgeon; one in ten against an internist and one in fourteen against an obstetrician.[11]

- A 1985 version of the study shows that one in five Alaska medical malpractice lawsuits through 1985 alleged a problem with surgery, while another one in five alleged a missed diagnosis.

- A MICA executive reported in a 1989 internal memorandum that among cancer patients the most common failure-to-diagnose claim in Alaska involved breast cancer and that failure to adequately

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[9]Frank Sloan, "Medical Malpractice Experience of Physicians: Predictable or Haphazard?" *Journal of the American Medical Association*, Vol. 262, No. 23, December 15, 1989.

[10]Ron Neupauer, underwriting manager, Medical Indemnity Exchange of California, letter to Representative Sam Cotten, November 3, 1989; and personal communication, January 14, 1992. The Harvard Medical Practice Study points out that the rate of claims is far too low compared to the rate of negligent injuries to draw conclusions about physician competence (p. 249).

[11]Rodman Wilson, M.D., "One Hundred Seventy-Nine Medical Malpractice Lawsuits in Alaska, 1977-1985," and "Specialty of Persons Named, 1978-1981," unpublished papers.

monitor anesthesia patients accounted for a large percentage of MICA's dollar losses in anesthesia cases.[12]

- MIEC's experience in Alaska and four other states mirrors the national estimate that about 3 percent of claims account for over 70 percent of loss costs, MIEC executive Ron Neupauer says.

- Fewer than 3 percent of Alaska physicians insured with MIEC had more than one paid claim between 1984 and 1989, Mr. Neupauer says.

ALASKA STATUTES

In the last two decades, Alaska legislators have made significant changes to the state's tort laws affecting medical malpractice litigation.[13] The changes affect judge and jury verdicts, but they also drive lawyers' decisions to settle medical malpractice claims. The Alaska Supreme Court has held Alaska hospitals responsible for the negligence of emergency room physicians employed on contract.

Among the Alaska statute changes since 1976 are the following:

- limits on noneconomic damages for negligence (AS 9.17.010);

- tightened requirements for punitive damages (AS 9.17.020);

- use of "collateral" sources of payment (AS 9.55.548); and

- arbitration of medical malpractice claims (AS 9.55.535)

Table 4 shows selected Alaska statute changes affecting medical malpractice since 1976.

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[12]Penne Chmielewski, memorandum to Mary Pierce, MICA, November 21, 1989.

[13]According to the New York law firm of Wilson, Elser, Moskowitz, Edelman and Dicker, states which enacted the most extensive tort reforms in 1986 include Alaska, Washington, Hawaii, Colorado, New Hampshire, New York, California, Florida and Illinois (David Rogers, "Almost Everything You Ever Wanted to Know About Liability Issues," Attachment # 3, report to Liability Insurance Task Force, Alaska State House, 1990, p. 13.)

TABLE 4
Alaska Legislation: Selected Medical Malpractice Remedies

Type of Remedy	Action Taken by Legislature	Year	Statute	Alaska Court Decisions Affecting Medical Malpractice
Insurance	Legislature created Medical Indemnity Corporation of Alaska (MICA) in 1976; repealed MICA in 1991.	1976 1991	21.88	
Peer Review	Legislature allowed peer review immunity unless the information given is false and known to be false.	1976	18.23.010	
Sanctions	Physicians are sanctioned for: – fraud, false advertising – felony conviction related to duties – drug crime; unlawful dispensing – professional incompetence – gross negligence – drug or alcohol abuse impairing ability to practice – demonstrated unfitness – unprofessional conduct –denying care to patient who does not arbitrate – Unconventional, experimental practice not reason for incompetence.	1983 1990	08.64.326	Professional incompetence standard is not unconstitutionally vague (Storrs v. State Medical Board 664 P.2d 547, cert. denied, 1983).
Reporting Requirements	A physician who treats the drug (or alcohol) addiction or mental illness of a licensed physician must report that treatment if the licensed physician is a danger to public. Hospitals must report denial of staff privileges.	1974 1983 1987 1990	08.64.336	
Provider Competence	Physicians must earn at least 15 hours of continuing medical education in five years.	1976	08.64.312	
Hospital Responsible	A hospital is liable for negligent care by an emergency room physician who is not an employee of the hospital, but is an independent contractor.			"We simply cannot fathom why liability should depend upon the technical employment status of the emergency room physician . . ." (Jackson v. Power, 743 P.2d 1376, 1987)
Risk Management	To be eligible for a license, hospitals must have internal risk management program that: – investigates frequency and cause of incidents – develops and sets up measures to minimize risk to public – analyzes patient grievances	1976	18.20.075	

TABLE 4
Alaska Legislation: Selected Medical Malpractice Remedies

Type of Remedy	Action Taken by Legislature	Year	Statute	Alaska Court Decisions Affecting Medical Malpractice
Arbitration	Patient and provider may agree to arbitrate any controversy which arises out of medical care. The patient may revoke within 30 days of execution, provider may not revoke.	1976 1978 1988	09.55.535	
Pretrial Screening	When parties do not agree to arbitrate, the court shall appoint expert advisory panel, unless such expert opinion is not necessary to the case. Panel report is admissible as evidence. If court finds a frivolous claim or defense, that party pays panel costs.	1976 1978	09.55.536	
Statute of Limitation	Action must be brought within two year (basic personal injury, tort limitation) For child: Action must be brought within two years after age 19.	1962 1979	09.10.070 09.10.140	
Ad Damnum Clause	Complaint or pleading need not list dollar amount of damages claimed.	1976	09.55.547	
Damages Limited	Noneconomic damages for negligence include payment for pain, suffering, inconvenience, physical impairment, disfigurement, loss of enjoyment of life and other nonpecuniary damage up to $500,000 for each separate incident, except for disfigurement or severe physical impairment.	1986	09.17.010	
Punitive Damages Limited	Punitive damages must include clear and convincing evidence.	1986	09.17.020	
Collateral Source Rule	After the fact finder has made an award, the provider may introduce evidence that the patient has received other ("collateral") payment for the injuries. The claimant can receive only the amount that exceeds payment from these collateral sources.	1967 1976	09.55.548	

TABLE 4
Alaska Legislation: Selected Medical Malpractice Remedies

Type of Remedy	Action Taken by Legislature	Year	Statute	Alaska Court Decisions Affecting Medical Malpractice
Joint and Several Liability	If more than one party is involved in an action, the court allocates a percentage of fault among them. A party which bears less than half of the fault may not be jointly liable for more than twice the percentage of fault which the court determined that party bears. Joint and several liability eliminated as of March 5, 1989: " The court shall enter judgment against each party liable on the basis of several liability in accordance with that party's percentage of fault." 9.17.080(d)	1986, 1987	09.17.080	
Advance Payments	Advance payments made by the defendant–provider to the plaintiff are not admissible and cannot be interpreted as admission of liability.	1976	09.55.546	
Informed Consent	Patient must show by preponderance of the evidence that the provider failed to inform the patient of common risks and reasonable alternatives.	1976	09.55.556	
Injury Alone Is Not Negligence	Jury is to be instructed that injury alone does not raise a presumption that the provider was negligent.	1967, 1976	09.55.550 09.55.540	"Language is clear and unambiguous" (Poulin v. Zartman, 542 P.2d 251, 1975) "There is good law to support the argument that the doctor need not inform the patient of all the hazards." (Patrick v. Sedwick, 391 P.2d 453, 1964) This section specifically rules out any presumptions of negligence in malpractice cases (Poulin v. Zartman, 542 P.2d 251, 1975 and rehearing 548 P.2d 1299, 1976).
Prejudgment Interest	Prejudgment interest of 10.5% Accrues from day process is served or day defendant receives written notice of injury and possible claim, whichever is earlier.	1962 1969 1980 1986	09.30.070	

Sources: The chart concept was borrowed from Roger Rosenblatt, et al, Tort Reform and the Obstetric Access Crisis: The Case of the WAMI States, WAMI Rural Health Research Center, University of Washington, Seattle, Washington, June 1990.

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The Alaska Supreme Court in a 1987 opinion, *Jackson v. Power*, ruled that a hospital is liable for the actions of the independent contractor physicians working in the emergency room. The case stemmed from May 22, 1981, when a 16-year-old boy fell off a cliff and was airlifted to the Fairbanks Memorial Hospital where one of two emergency room physicians on duty examined him and ordered several tests but not tests which could have revealed injuries that caused the boy to lose both kidneys.

The boy and his mother went to court, arguing that the hospital was vicariously liable for the care rendered by the physician. A state superior court judge disagreed and the case was appealed to the Alaska Supreme Court, which held with the plaintiffs:

> "[W]e simply cannot fathom why liability should depend upon the technical employment status of the emergency room physician who treats the patient. It is the hospital's duty to provide the physician, which it may do through any means at its disposal. The means employed, however, will not change the fact that the hospital will be responsible for the care rendered by physicians it has a duty to provide" [*Jackson v. Power* 743 P.2d 1376 (1987)].

The case was later settled out of court for $3.5 million dollars.

The next two sections of this report show number and severity of medical malpractice claims in Alaska.

ALASKA: NUMBER OF MEDICAL MALPRACTICE CLAIMS

Experts say Alaskans file medical malpractice claims at a higher rate than people in other states. Insurance company records show more than seven malpractice claims a month filed in Alaska between 1983 and 1988. One insurance executive confirms that Alaska's rate of claims filed per insured physician has dropped in the last "four or five years." Court records show an average of more than two medical malpractice lawsuits a month filed in Alaska between 1977 and 1989. Almost two lawsuits a month were filed in Anchorage alone between August 1988 and February 1992. **The number of Alaska medical malpractice lawsuits peaked in the mid 1980s and shows no definite trend today.**

Because state law does not require malpractice insurers to report claims information, it is difficult to obtain up-to-date data about the number and

rate of medical liability claims in Alaska.[14] For details about claims, this report relies on computer spreadsheets showing claims filed and pending or paid from 1977 through the fall of 1989. MICA and MIEC supplied the spreadsheets to the House Liability Task Force in 1989. The lists, which were printed in September and November of 1989, are on file in the Alaska Legislative Reference Library. Additional sources include reports provided by the Alaska Court System; reports from the Alaska State Medical Association; and the records of Dr. Rodman Wilson, who helped create MICA.[15] The results are discussed in the next paragraphs and pictured in the graphs which follow.

Ron Neupauer of MIEC reports that Alaska's claims rate per insured physician is higher than in the four other states in which his company does business (California, Hawaii, Idaho and Nevada).

- Insurance company computer data sheets show more than seven Alaska malpractice claims filed a month between 1983 and 1988. This includes nearly three formal claims and lawsuits a month filed with MICA and 4.6 claims of all types (including reports of possible problems from physicians and hospitals) a month filed with MIEC.[16]

- **Graph 1 (MICA 1977-September 1989):** In this graph, "claims" are defined as medical malpractice lawsuits and formal written claims to the insurer.[17]

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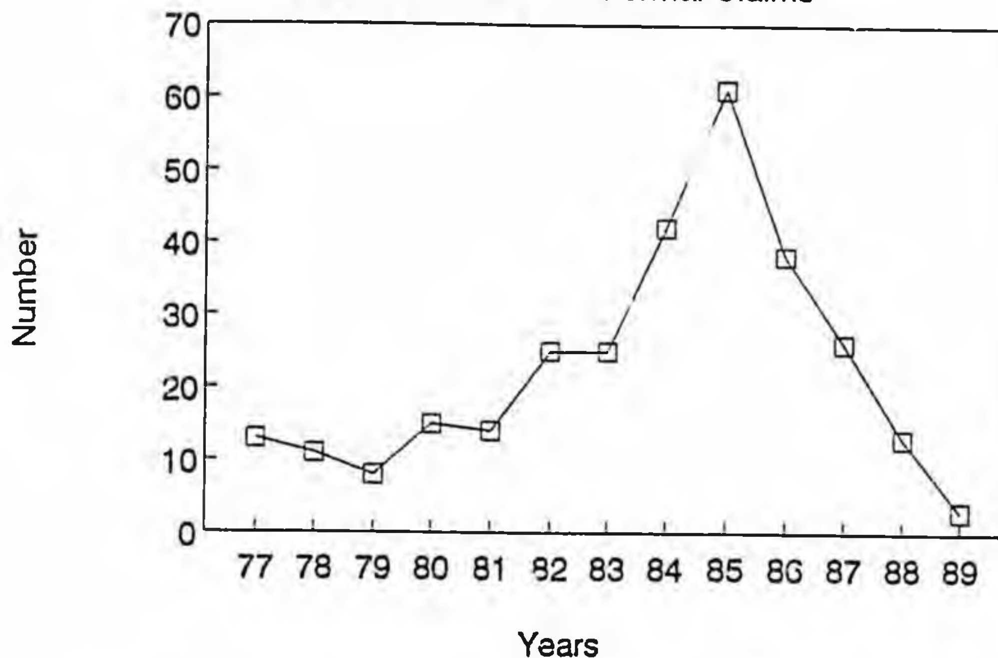
[14]Among states requiring liability carriers to report all claims are Alabama, Delaware, Iowa, Kansas, Maine, Massachusetts, Michigan, Missouri, Nevada, New Hampshire, New York, North Carolina, Oklahoma, Oregon, Rhode Island, Texas, Virginia, West Virginia, Wisconsin, and Wyoming. Arizona requires plaintiff attorney to report (from a table provided by Ilene Johnson, general counsel, American Medical Association).

[15]Diane Alford of the Alaska Court System in Anchorage and Deb Carlson of the Alaska State Medical Association used their own time, including weekends, to collect medical malpractice lawsuit data from their agencies.

[16]Number of claims from Ron Neupauer, faxed memorandum, February 26, 1992, in response to a February 25, 1992 written request for information. The quotation is from a personal communication with Mr. Neupauer, February 25, 1992.

[17]MICA computer run, current as of September 30, 1989, supplied to the Alaska State House Liability Task Force and on file in the state legislative library.



MICA Claims (Severity "4" and 5" only)
Through September 30, 1989

1977	13	1981	14	1985	61
1978	11	1982	25	1986	38
1979	8	1983	25	1987	26
1980	15	1984	42	1988	13
				1989	3

Note: 1989 data are incomplete.

Source: MICA computer runs through September 30, 1989, provided to the House Liability Task Force, on file at the Alaska Legislative Reference Library.

(91.222GA)

- **Graph 2 (MIEC 1980-1991):** "Claims" are defined as all claims reported (a larger group than the MICA list).[18]

MICA began writing malpractice insurance in Alaska in 1977 and MIEC in 1978. The appendix includes a list of all MICA formal claims and lawsuits and all MIEC reported claims from 1977 through the fall of 1989.

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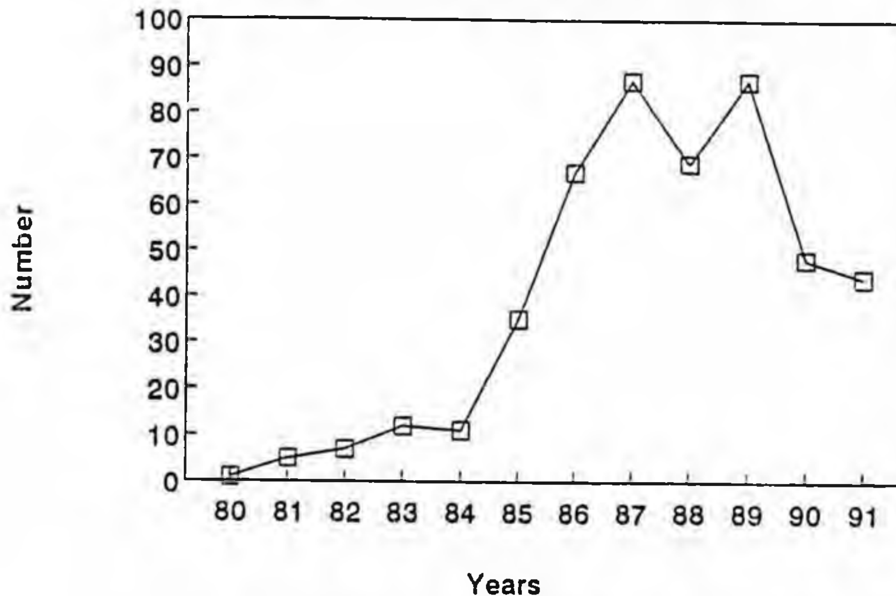
[18]Ron Neupauer, faxed transmission, February 26, 1992.

GRAPH 2

MIEC Reported Claims 1980 – 1991



MIEC REPORTED CLAIMS (ALL SEVERITIES) THROUGH 1991

1980	1	1984	11	1988	69
1981	5	1985	35	1989	87
1982	7	1986	67	1990	48
1983	12	1987	87	1991	44

Note: Claims of all severities reported by policy holders; 1991 data are incomplete.

Source: Ron Neupauer, faxed transmission, February 26, 1992.

(91–222GB)

Under Alaska law, most medical malpractice lawsuits must pass through a state expert advisory panel before they can move to trial.[19] The panel looks for injury from medical care and if it finds that injury, investigates whether it was caused by "unskillful" care.[20] The number of lawsuits processed by the expert advisory panel gives a rough indication of the number of medical malpractice lawsuits filed in Alaska.

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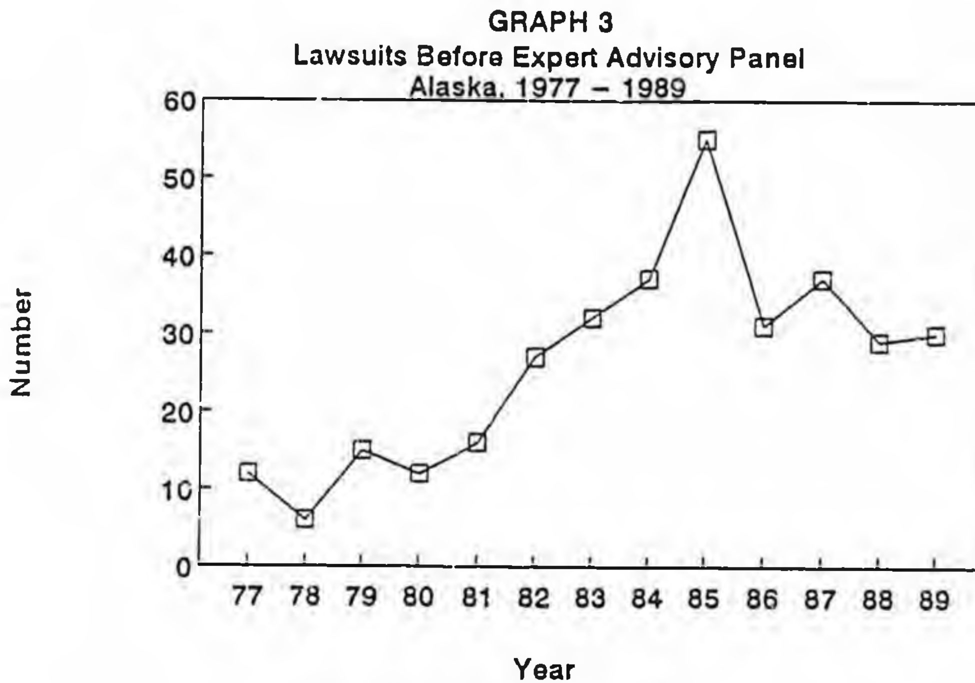
[19]Alaska Statute 09.55.536.

[20]Dr. Rodman Wilson, who helped create the expert advisory panel system in 1976, points out that the panel determines whether care was "unskillful," not whether it was "negligent." He says the distinction is important because it allows the panelists to confine their opinion to medical rather than legal questions. "Alaska's Medical Advisory Panel System for Malpractice Lawsuits," unpublished paper, February 13, 1983.

- Graph 3 (Expert Advisory Panel) shows 401 medical malpractice lawsuits filed for review from 1978 through February 1992, or an average of about 29 lawsuits a year (2.4 per month). The trend shown on Graph 3 is for the years 1977 through 1989 statewide.



Lawuits Before Expert Advisory Panel

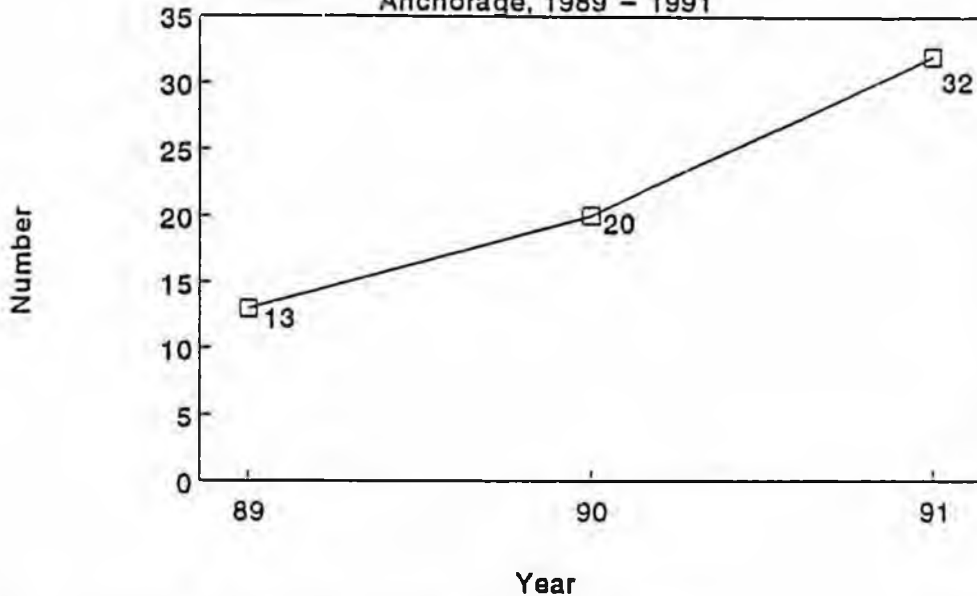
1977	12	1981	16	1985	55
1978	6	1982	27	1986	31
1979	15	1983	32	1987	37
1980	12	1984	37	1988	29
				1989	30

Note: 1989 data are incomplete.

Source: "Expert Advisory Panel Data," Alaska State Medical Association, provided to House Liability Task Force, on file at Alaska Legislative Reference Library.
(91-222GC)

- Graph 4 (Lawsuits filed in Anchorage shows 65 medical malpractice lawsuits filed in Anchorage alone between 1989 and December 1991 (and three more through February 1992), or about 1.7 a month. Four advisory panels were to report on Anchorage lawsuits in March and April 1992 (March 5, March 16, March 20 and April 20). Eleven Anchorage lawsuits, including several filed in 1989 and 1990, are awaiting panel appointments.

GRAPH 4
Medical Malpractice Lawsuits Filed
Anchorage, 1989 - 1991



Source: Alaska Court System, Clerk's Office, Anchorage. (91-222GD)

The appendix includes a list of Anchorage medical malpractice lawsuits and their status with the panel from August 1988 through February 1992.

ALASKA: SETTLEMENTS AND VERDICTS

A decade ago, an observer of the Alaska medical liability scene noted that no Alaska malpractice award or settlement had ever exceeded $500,000. That is no longer the case. In 1988 and 1989 alone, insurance companies paid four Alaska claims of about $2 million each and a fifth for almost $3 million. Meanwhile, in federal court, a judge ordered $5 million damages against one Alaska federal hospital in 1988 and $8 million against another in 1989. In Alaska, as elsewhere, very few medical malpractice claims go to a judge or jury. Most medical malpractice claims are dropped or quietly settled in a lawyer's office. When the settlement is sealed, the amount--and sometimes the very existence of the case--can be kept secret.

The insurance company records used as sources for this section end in the fall of 1989. They were provided to the House Liability Task Force, which met in 1990, and are on file with the Alaska Legislative Research Library. Other sources include a report from Jury Verdict Research in Ohio, interviews with lawyers and the research of Dr. Rodman Wilson of Anchorage. The information presented here is spotty and incomplete. It is offered as a crude barometer of the medical malpractice "climate" in Alaska. Without a central and

accessible database recording payments in past years, it is difficult to be more accurate.

- In 1983, Dr. Rodman Wilson, who as an Anchorage internist helped develop MICA in the 1970s and who today remains an active observer of the state liability scene, wrote that "there has never been an award or settlement in excess of $500,000 in a medical malpractice action in Alaska."[21] That is no longer the case. Insurance payments on behalf of Alaska physicians and hospitals in 1988 and 1989 alone ranged from $1.8 million to $2.8 million (see Table 6). These insurance records do not show two federal court verdicts of $5 million and $8 million in 1988 and 1989 against federal hospitals and paid with federal funds. These verdicts are described in the next section.

- Experienced liability lawyers say, typically, dollar amounts of Alaska medical malpractice settlements are "far higher" than verdicts.

- No Alaska clearinghouse collects data on amounts paid since the 1970s to satisfy medical malpractice claims against Alaska physicians and hospitals. This will change in the future. Under state law, physicians (but not hospitals) have been required since June 15, 1990 to report "the outcome of each medical malpractice claim or civil action in which damages have been or are to be paid . . . whether by judgment or under a settlement" (AS 8.64.345).[22] Beginning September 1, 1990, federal law requires insurance companies to report current paid medical malpractice claims (the National Practitioner Data Bank, 800-767-6732 for helpline; detailed information on file at the Alaska Legislative Research Agency Library).

These statistics will be helpful for future legislatures, but they provide little guidance for lawmakers approaching medical liability today. To accurately assess the effectiveness of early tort reforms in Alaska, it is essential to know the trend in medical malpractice payments made on behalf of physicians and hospitals.

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[21]Dr. Rodman Wilson, "Alaska's Medical Advisory Panel System for Malpractice Lawsuits," unpublished manuscript, February 13, 1983.

[22]The language of the statute has created some confusion, however. It is unclear whether physicians are to report damages decreed in settlement or verdict, or damages actually paid. As an article in the *National Law Journal* points out, after they are agreed upon, settlements and verdicts can be reduced by several devices, including structured payments, post-trial motions, and agreements to limit damages to policy limits ("1991's Largest Verdicts," January 20, 1992, special section).

Alaska Paid Claims

Records of claims paid through the fall of 1989 and after mid-1990 show roughly $25 million in payments to satisfy medical malpractice claims against Alaska physicians and hospitals since 1977, another $4 million reported by physicians since mid-1990 and more than $5 million in defense expenses. The actual total is higher. The estimate above does not include most payments by self-insured physicians and hospitals, any payments between late 1989 and mid-1990, any hospital payments and defense expenses after 1990, or any damages determined in federal court. An average of more than one practicing Alaska physician a month has reported malpractice settlements or verdicts since mid-1990 under a new state law.

The appendix includes a list of medical malpractice payments by MICA and MIEC from inception through the fall of 1989. In this report, the lists, provided to the House Liability Task Force in 1990, were used to calculate total payments through the fall of 1989.[23] A list of physician reports to the Alaska State Medical Board, was the source of totals after June 1990 (see Table 5). In summary, the totals include:

- $4.2 million in payments reported by physicians under a state law which went into effect in June 1990 (AS 8.64.345). Some 26 physicians have reported settlements or verdicts, an average of more than one a month, but lawyers say some settlements are not on the list. Another 10 physicians applying for a license to practice in Alaska have reported previous payments in other states. These reports do not include defense expenses, nor do they include hospitals;[24]

- $19.7 million in payments and $4.0 million in defense expenses through MICA through September 30, 1989; and

- $4.9 million in payments and $1.2 million in defense expenses through MIEC through November 21, 1989.

The total does not include claims paid on behalf of physicians and hospitals between the fall of 1989 and June 15, 1990 and by hospitals after June 15, 1990; claims paid before 1990 by self-insured physicians or hospitals; payments

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[23]Defense expenses include lawyers' fees and costs of expert witnesses and computer research. Sources for payment totals are MICA computer runs current through September 30, 1989 and MIEC computer runs current through November 21, 1989 (provided to the Alaska State House Liability Task Force and on file at the Alaska Legislative Reference Library). 1990-1992 data are from Alaska State Medical Board computer run current through February 20, 1992.

[24]Alaska State Medical Board computer run, February 20, 1992.

made after June 15, 1990 but unreported by physicians; or verdicts handed down in federal court.

MICA reports that between 1976 and 1988, the average payment for all claims was $48,730 and the average payment for all paid claims was $124,353. In 1991, the average paid claim was $89,093 (for 11 paid claims), with a high of $200,000 and a low of $12,500. Payments included a jury verdict of $150,387.[25]

MICA reports that six out of ten of all its Alaska claims (including any incidents reported by physicians and hospitals) result in zero payment to the patient.[26] On the other hand, Table 6 shows that insurers have made sizeable payments on behalf of Alaska physicians and hospitals. Table 6 is taken from the list of all claims paid and pending through the fall of 1989 by MICA and MIEC provided to the House Liability Task Force in 1990. Among the large payments reported are:[27]

- a $2.8 million payment closed in 1988 (MICA; settlement involving a brain damaged child);
- a $2.2 million payment closed in 1988 (MICA; settlement involving allegations of negligent prenatal care);
- a $1.9 million payment closed in 1989 (MICA; allegations of negligence by an emergency room physician);
- a $1.8 million payment closed in 1989 (MIEC);
- a $1.75 million payment closed in 1988 (MICA; jury verdict involving emergency room care); and
- seven payments between $500,000 and $1 million (1 MIEC, 6 MICA).

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[25]MICA: "All Claims -- Inception Through 1988," and letter from Jan Johnston, March 11, 1992, p. 3.

[26]Letter from Janet Johnston, March 11, 1992.

[27]Letter from Janet Johnston, March 11, 1992 and MICA spreadsheets of claims pending and paid, September 30, 1989.

TABLE 5
PAYMENTS REPORTED
ALASKA STATE MEDICAL BOARD
June 15, 1990 to February 20, 1992

Practicing in Alaska

Doctor	Amount	Date Paid	Source of Report (1)	Comments
1	71,500	6/25/91	NPDB	Alleged sexual misconduct
2	130,000	8/23/90	.345	*
3	145,000	12/27/91	.345	Alleged unnecessary sinus surgery
4	128,859	1/16/92	NPDB	*
5	534,550	*	.345	Settled out of court after suit filed; extensively reviewed by hospital, MICA risk committee
6	125,000	7/1/91	.345	Alleged negligence due to infection after surgery
7	75,000	*	.345	Patient's estate negotiated settlement prior to lawsuit
8	28,000	8/23/91	NPDB	Expert advisory panel found no fault
9	120,000	8/1/90	.345	Alleged negligent hernia repair resulted in removal of testicle
"	15,000	10/8/91	NPDB	Settled after suit was filed
10	128,859	1/16/92	NPDB	*
11	230,000	*	.345	Settled out of court prior to lawsuit
12	55,000	6/14/91	NPDB	Alleged misdiagnosis of hand burns
13	90,000	4/27/90	.345	*
"	150,387	6/17/91	NPDB	Alleged unnecessary surgery without full consent
14	200,000	6/30/91	.345	Alleged failure to diagnose
15	269,112	3/17/91	NPDB	Alleged error during multiple by-pass surgery
16	*	1/1/90	.345	Alleged failure to diagnose depression and over-prescription
17	10,750	5/7/91	.345	Retained sponge; discovered during second surgery
18	140,000	9/23/91	NPDB	Improper use of hypnosis; sexual assault
19	7,500	11/8/90	NPDB	Alleged need for surgery to correct obstruction
20	30,000	11/22/91	NPDB	Retained sponge; subsequent complications, two more surgeries
21	4,000	1/16/92	NPDB	*
22	6,983	4/29/91	.345	Payment of out-of-pocket medical expenses
23	15,000	12/21/90	.345	Settled by carrier after M.D. was dropped from suit
24	450,000	*	.345	Patient's estate settled prior to lawsuit
25	500,000	10/30/91	NPDB	Jury verdict
26	550,000	*	.345	Jury verdict
TOTAL	4,210,500			

* indicates information not reported.

Note: Double entries are considered a single incident if reported from different sources, "dates paid" are close and amounts paid are exactly the same.

(1) NPDB = Reported to National Practitioners Data Bank; .345 = report by physician to Alaska State Medical Board (A.S. 9.64.345)

Source: Alaska State Medical Board (91.222TE)

TABLE 6
Payments on Behalf of Alaska Providers, $100,000 and Above, Through Fall, 1989

MEIC

Year Claim	Year Close	Specialty	Payment	Cost
1982	1989	Anesthesiology	$1.8 million	$94,948
1982	1986	Orthopedics	$756,747	$40,929
1981	1987	Otolaryngology	$446,000	$66,997
1967	1989	Surgery	$425,000	$8,559
1987	1989	Otolaryngology	$380,000	$145,664
1984	1988	Orthopedics	$275,000	$33,693
1985	1987	Radiology	$250,000	$29,232
1986	1989	Neurology	$173,000	$54,516
1981	1985	Neurological Surgery	$125,000	$14,497
1983	1985	Internal Medicine	$104,000	$8,453

MICA

Year Claim	Year Close	Specialty	Payment	Cost
1985	1988	Not Available	$2.8 million	$124,447
1985	1988	"	$2.2 million	$13,046
1984	1989	"	$1.9 million	$246,132
1984	1988	"	$1.8 million	$395,253
1985	1986	"	$800,000	$6,487
1983	1986	"	$750,000	$13,206
1986	Pndg	"	$628,000	$88,231
1983	1985	"	$550,000	$32,664
1984	1986	"	$584,000	$18,300
1986	1986	"	$513,000	$1,639
1984	1986	"	$503,625	$18,266
1986	1987	"	$400,000	$24,000
1983	1984	"	$334,000	$25,379
1984	1986	"	$312,500	$12,170
1986	Pndg	"	$300,000	$72,651
1986	1989	"	$300,000	$9,186
1982	1985	"	$230,000	$11,395
1980	1983	"	$220,000	$85,268
1977	1981	"	$200,000	$11,288
1984	1987	"	$190,000	$36,359
1984	1986	"	$187,000	$2,500
1987	1988	"	$185,000	$19,133
1985	1987	"	$175,000	$10,878
1986	Pndg	"	$171,000	$105,252
1986	Pndg	"	$171,000	$103,492
1984	1986	"	$170,000	$15,000
1985	1987	"	$163,500	$39,417
1977	1979	"	$150,000	$11,453
1982	1987	"	$150,000	$24,913
1982	1987	"	$150,000	$21,933
1981	1982	"	$142,500	$35,688
1986	1988	"	$112,500	$17,565
1983	1984	"	$112,500	$10,886
1986	1987	"	$100,000	$11,024
1986	1987	"	$100,000	$10,886
1985	1985	"	$100,000	$2,307
1982	1983	"	$100,000	$3,935

Source: Insurance carrier computer runs through Fall 1989 provided to the House Liability Task Force and on file in the Alaska Legislative Reference Library.

(91.222TF)

Alaska Court and Jury Verdicts

Few medical malpractice lawsuits have gone to the jury in Alaska and, nationwide, few medical malpractice juries return verdicts against doctors. In 1988, however, an Alaska jury handed down a verdict of $1.75 million against a hospital, and more recently, an Alaska jury returned a verdict of $500,000 against a physician and another returned a verdict of $550,000 against a physician group.

Although jury verdicts are usually public, information on medical malpractice verdicts is not systematically collected in this state. It is beyond the scope of this report to attempt to offer precise data, but the appendix does provide information about some two dozen court and jury verdicts since the early 1960s. The information was gleaned from conversations with lawyers, state Supreme Court opinions, a study by Jury Verdict Research in Ohio, a 1975 *Anchorage Daily News* study and a study of lawsuits before expert advisory panels.[28] It is dated and incomplete and--because cases are old and memories become fuzzy--it may contain inaccuracies. It is offered only as a glimpse at Alaska jury and court verdicts.

Among recent large judge or jury verdicts against Alaska hospitals and physicians are:

- $8.3 million in a 1983 obstetrics case involving a prolapsed umbilical cord at Alaska Native Medical Center. The case was filed in 1987 and resolved in a court trial in 1989. Payment is made by the federal government (*Heflin v. U.S.A.*, reported by Jury Verdict Research);

- $5[illegible] million in a 1984 case involving a two-year-old with [illegible]agnosed meningitis which caused brain damage. The case was [illegible]d in 1985 against a federal hospital in Bethel and resolved in a court trial in 1988. Payment is made by the federal government (*Yako v. U.S.A.*, reported by Jury Verdict Research);

- $1.75 million against an Anchorage hospital for failure to diagnose an aneurysm in the emergency room. The case was resolved in a 1988 trial. (*Justice v. Humana* 3AN-86-00122, reported by Jury Verdict Research);

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[28] Jan Johnson, formerly of MICA and now of NORCAL, was recommended by doctors and lawyers as a source of information about claims outcomes, but she said during two conversations for this report that she was uncomfortable discussing outcomes.

- $550,000 against physicians at Faith Hospital involving loss of eyesight (*Routt v. Physicians with SEND* 3AN-87-2033, reported by the Alaska State Medical Board);

- $500,000 paid in 1991 after injuries from chemotherapy on a 19-year-old outpatient diagnosed with testicular cancer (*Mellott v. Stewart* 3AN-87-2033); and

- $210,000 paid after a 1989 verdict in a claim involving facial paralysis (*Germain v. Nathanson*)

Defense and plaintiff lawyers report more recent settlements in the million-dollar and higher range, as well as jury verdicts in favor of the defense, including one involving complex orthopedic surgery and one involving a newborn. Scheduled for trial in April is an obstetrics case against an Anchorage emergency room physician in which a first physician settled for $500,000 and the hospital for more than $2 million.

One Alaska expert in malpractice law says doctors are "treated very well by juries in this state." Another defense lawyer notes that, like prosecutors, malpractice defense lawyers take to trial cases they think they can win, hence zero verdicts. But juries are unpredictable:

- In a 1986 Alaska case, the defense rejected a patient's settlement offer of $658,000, only to have the jury render a verdict of more than $1.4 million (reported by Jury Verdict Research);

- In a 1991 case, the provider settled for $1 million during jury deliberation, only to find out the jury would have found for the doctor (reported by the attorney); and

- Juror affidavits in a 1973 trial which ended in the doctor's favor show that the case would have gone to the plaintiff (at one point the vote was said to be 11 to 1 against the doctor) except that jurors did not like the plaintiffs and did not want the lawyers and parents to be the primary beneficiaries of the award (from the court opinion).

Legal Expenses in Alaska Malpractice Claims

Insurance company spreadsheets show that insurers paid more than $5 million through the fall of 1989 to defend medical malpractice claims against Alaska physicians and hospitals. On the other side, plaintiff lawyers typically collect between 33 percent and 40 percent of damages. Except for one MICA examination of four cases showing contingency fees between 33 and 40 percent in the late 1980s, no study released to the public examines Alaska defense costs or contingency fees.

Defense Attorney Costs

One insurer says his company expects to spend at least $250,000 in legal fees if a case goes to trial. Another says defense costs averaged among all claims are about $16,000 and the average cost of defending a case through trial is around $60,000.

- Computer runs from 1989 show defense expenses as high as $395,000 for a case with a payment of $1,750,500 (through MICA) and $355,000 for a case with zero payment (through MIEC).

- The documents also show defense payments of as little as $3.

Plaintiff Attorney Fees

Patients who file lawsuits against physicians or hospitals typically pay their lawyers 33 to 40 percent of the final settlement or verdict--if there is one. Plaintiffs' attorneys pay all expenses in medical malpractice cases up front. They usually are not reimbursed unless the patient recovers money in a settlement or verdict. One Anchorage plaintiff attorney says expenses are so high that he takes few medical malpractice cases that promise damages of less than $300,000 to $400,000; another sets his bottom limit at $100,000 potential.

- A recent medical malpractice trial involved over one year's work for a total cost to the plaintiff lawyer of $260,000. The result was a verdict for the defense and the plaintiff lawyer recouped none of the expense of the case.

- One plaintiff lawyer says it is impossible to take a medical malpractice case to trial in Alaska for less than $75,000, partly because it is expensive to hire expert witnesses and bring them to the state. He said the state's expert advisory panel system, with its state panel of local physician experts, requires the plaintiff to hire known expert witnesses.

Most MICA Claims: One to Three Years

The director of the state Division of Insurance says shortening the time it takes from filing to resolution of malpractice claims will cut down on expense. "The more quickly claims are resolved, the less expensive they will be," director Dave Walsh told members of the Health Resource and Access Task Force in March.[29]

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[29]Dave Walsh, commenting as a member of the Health Resources and Access Task, Juneau, March 14, 1992.

Most MICA claims closed between 1984 and 1988 were resolved in from one to three years, according to an undated letter from the company's then executive director.[30] Some seventeen claims took four years to resolve, seven took five years, one took six years, three took seven years and one took nine years, according to the letter. A Norcal executive previously employed with MICA, however, says problems with definition and different interpretation of actual report dates make it difficult to provide accurate information on the length of a claims "tail." She offers anecdotes from both ends of the scale. On the one hand, a November 27, 1991 claim was resolved on February 18, 1992 with a payment of $225,000 (less than 12 weeks). On the other hand, a February 1987 incident is scheduled for trial at the end of 1992 (the case was delayed because the patient's medical condition changed).[31]

Plaintiffs Win Fewer Than Half of All Claims

Nationwide, medical malpractice experts believe that fewer than half of all medical malpractice claims result in any payment for the claimant. Randall Bovbjerg of the Urban Institute estimates that 27 percent of plaintiffs in medical malpractice claims recover, Patricia Danzon of the Wharton School estimates 40 percent and the Harvard Medical Practice Study estimates no more than half. Norcal reports a 41 percent recovery rate.[32] Experts in medical liability estimate that less than half of the premium dollar goes to the patient (similarly, one actuary believes that only half of the total costs of the tort system go to the plaintiff).[33]

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[30]Medical Indemnity Corporation of Alaska "Claims Closed With No Indemnity Payment" and "Claims Closed With Indemnity Payment", Attachment # 3A and 3B, letter to Jetta Whittaker from Mary Pierce, executive director, MICA, no date.

[31]Letter from Janet Johnston, March 11, 1992.

[32]About 27 percent of closed obstetric malpractice claims result in payment to the patient. Randall Bovbjerg, et al., "Obstetrics and Malpractice: Evidence on the Performance of a Selective No-Fault System," *Journal of the American Medical Association*, Vol. 265, No. 21, June 5, 1991, p. 2836. About 40 percent of closed claims result in payment to the plaintiff. Patricia Danzon, *Medical Malpractice, Theory, Evidence and Public Policy*, *op. cit.*, p. 24. No more than half of medical malpractice closed claims result in recovery of damages to the patient. The Harvard Medical Practice Study, *op. cit.* Norcal report from Janet Johnston letter, March 11, 1992.

[33]An executive with Tillinghast/Towers Perrin reports that 25 percent of total costs in the tort system go for pain and suffering awards and 25 percent for economic loss awards. He says the rest goes for administration, handling, defense attorney costs and plaintiff attorney costs. Robert Sturgis, "Tort Cost Trends: An International Perspective," a presentation to the American Insurance Association, Tillinghast/Towers Perrin, 1985.

Table 7, which documents the national 27 percent recovery estimate, charts the career of closed obstetrics claims in a national sample between August 1983 and February 1989. The final column to the right shows the percent of patients who recover. It also shows average payments of $147,000 (including cases with zero recovery). The average case took 33 months to resolve.

TABLE 7
Obstetric Malpractice Claims by Stage of Resolution, 24 States, 1983–1989

	No Info.	Before Claim	Before Suit	Arbitration	Litigation	After Trial	All Cases
Number	9	130	41	9	92	4	285
Percent Paid	33%	4%	17%	78%	58%	50%	27%
Mean Payments (1)	$15,103	$493	$5,643	$213,656	$403,212	$580,605	$146,569
Mean Expenses (2)	$3,935	$969	$1,445	$13,643	$33,769	$99,587	$13,503
Median Injury Severity (3)	2	3	4	3	6.5	7.5	4
Months to Resolve	52	23	25	30	48	58	33

(1) All cases, all defendants
(2) All cases, hospital defendants
(3) Nine point scale: Emotional damage – 1; Temporary Injury: insignificant – 2, minor – 3, major – 4; Permanent Injury: minor – 5; significant – 6; major – 7; grave – 8; Death – 9.

Source: Randall Bovbjerg, et al., "Obstetrics and Malpractice: Evidence on the Performance of a Selective No–Fault System," Journal of the American Medical Association, June 5, 1991, p. 2839.

(91–222TG)

Settlements: **Secret and With Little Oversight**

Observers note that there is little public, judicial or medical oversight during the informal negotiations leading a malpractice claim to settlement. One exception is juvenile cases. Alaska Civil Rule 90.2 requires court approval of all settlements involving juveniles. Juvenile cases, however, are closed to the public.

One lawyer who specializes in medical malpractice plaintiff work says medical malpractice cases cannot be thrown wide open to public scrutiny because without some protection of their identity and reputations, physicians will be loath to approve any settlement. He urges strengthening the enforcement powers of the

Alaska State Medical Board. A good surgeon can make a mistake, should have to compensate the victim, and should be allowed to continue practicing, this lawyer says. A bad surgeon should be stopped from practicing medicine.

ALASKA: COST OF MEDICAL MALPRACTICE PREMIUMS

The cost of Alaska medical malpractice premiums has "stabilized," according to a Norcal executive who insisted on anonymity for this report. Premium costs vary by specialty. One Alaska physician suggests that all doctors should pay the same malpractice rates "because we are all equally negligent." In 1992, premiums ranged from $4,520 to $90,169, depending on the specialty and the amount of coverage desired. Premiums cost the same whether the physician is urban or rural or has a history of few or many claims.

- The state director of the Division of Insurance predicts Alaska medical malpractice premium rates will "come down and be fairly stable."[34]

- Norcal makes no distinction between the cost of premiums sold in urban Alaska and those sold in rural Alaska. Norcal premiums are priced by the physician's specialty, not by number of paid claims, according to Art Stanford, Norcal underwriting manager. Mr. Stanford says his company can refuse to sell insurance to physicians with large losses, "but it doesn't happen too often." He says size of loss is less significant than whether the physician met the appropriate standard of care. "We would be far more critical of those cases [nominal settlements but care substantially below standard] than ones in which large amounts were paid but the treatment did not . . . fall below the standard of care," he says.[35]

- Premium rates should be the same among all doctors, Dr. Rodman Wilson, a retired internist and long-time observer of Alaska medical malpractice issues, told fellow members of the Health Resources and Access Task Force at a March meeting in Juneau. Pointing out that certain specialties are more likely targets because the injuries are more obvious, he said, "Malpractice rates ought to be the same for all doctors, because we are all equally negligent."

Norcal malpractice premiums in 1992 for physicians who have practiced for five years or more range from $4,520 for a pathologist with the lowest risk and

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[34]Dave Walsh, comments before the Health Resources and Access Task Force, Juneau, March 14, 1992.

[35]Letter from Art Stanford, March 11, 1992.

lowest level of coverage to $90,169 for an orthopedic surgeon with the highest risk and highest level of coverage. Table 8 shows 1992 premium costs by specialty in Alaska. Physicians insured with Norcal are most likely to choose $500,000/$1 million coverage (that is, $500,000 per occurrence, but no more than $1 million total payments in one year).[36]

TABLE 8
Annual Malpractice Premiums by Specialty, Alaska 1992

Specialty In Order of Risk (Low to High)	Norcal $200,000/$600,000	Norcal $500,000/$1 million	Norcal $1 million/$3 million	MEIC $1 million/$3 million
Pathologist	4,520	5,697	7,673	8,232
Allergist	6,846	8,808	12,102	8,232
Family Practitioner (no obstetrics)	6,846	8,808	12,102	10,584
Pediatrician	6,846	8,808	12,102	10,584
Ophthamologist	8,843	11,478	15,904	13,524 (1) 26,456 (2)
Internist	10,946	14,291	19,903	11,760 (3) 17,636 (4)
General Practitioner (with minor surgery)	10,946	14,291	19,903	17,636
Emergency Room	15,633	20,558	28,830	26,456
Anesthesiologist	18,820	24,819	34,896	26,456
General or Family Practitioner (w/obstetrics)	20,319	26,824	37,751	79,948 (5)
Obstetrician/Gynocologist	34,379	45,627	64,519	79,948
Plastic Surgeon	34,379	45,627	64,519	42,328
Orthopedist	47,855	63,645	90,169	42,328 (6) 79,948 (7)

NOTE: Physicians in fifth year or more experience category

(1) Excluding radial keratotomy
(2) Including procedure in (1)
(3) Excluding cardiac catheterization, angioplasty
(4) Including procedures in (3)
(5) MIEC classifies these physicians in highest-risk category
(6) Excluding spinal surgery and use of chymopapain
(7) Including procedures in (6)

Source: MIEC, "Claims-Made Professional Liability Premium Schedule (Quarterly)"; and Norcal, "Development of Rate Indications, Alaska, June 1991." (91.222TH)

[36] Letter from Art Stanford, March 11, 1992.

Premiums Collected versus Payments Made

Alaska physicians and hospitals paid an average of $10.5 million a year in medical malpractice premiums between 1984 and 1990 (a total of $73.3 million in seven years). The high was $15.5 million paid in 1989, the low was $3.4 million in 1984. Studies show that physicians and hospitals quickly pass premium costs on to patients.

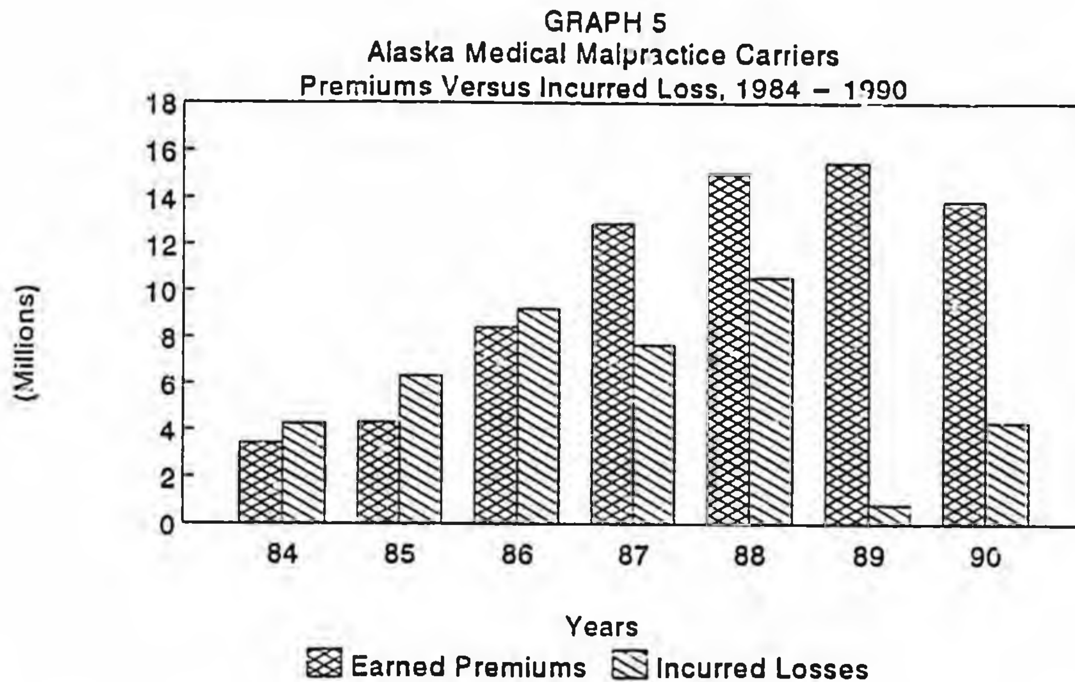
The list below and Graph 5 show state Division of Insurance reports of the medical malpractice premiums earned and losses incurred in Alaska by companies selling this type of insurance between 1984 and 1990.[37] Incurred losses are amounts companies pay on claims during a year plus the net change in reserves for estimated future payments to claimants.[38] These figures are not the same as dollars actually paid out in a year to satisfy medical malpractice settlements and verdicts.

	EARNED PREMIUMS	INCURRED LOSSES
1984:	$ 3,410,000	$ 4,281,000
1985:	$ 4,329,000	$ 6,335,000
1986:	$ 8,413,000	$ 9,187,000
1987:	$12,871,000	$ 7,638,000
1988:	$15,004,000	$10,540,000
1989:	$15,461,000	$ 830,000
1990:	$13,812,000	$ 4,336,000
TOTAL:	$73,300,000	$43,147,000
AVERAGE:	$10,471,000	$ 6,163,857

[37]Memorandum from Stan Garlington, market analyst, to David J. Walsh, director, Division of Insurance, Alaska Department of Commerce and Economic Development, March 11, 1992.

[38]The definition comes from James Kakalik and Nicholas Pace, *Costs and Compensation Paid in Tort Litigation*, The Rand Corporation, 1986, p. 137.

GRAPH 5
Alaska Medical Malpractice Carriers
Premiums Versus Incurred Loss, 1984 – 1990

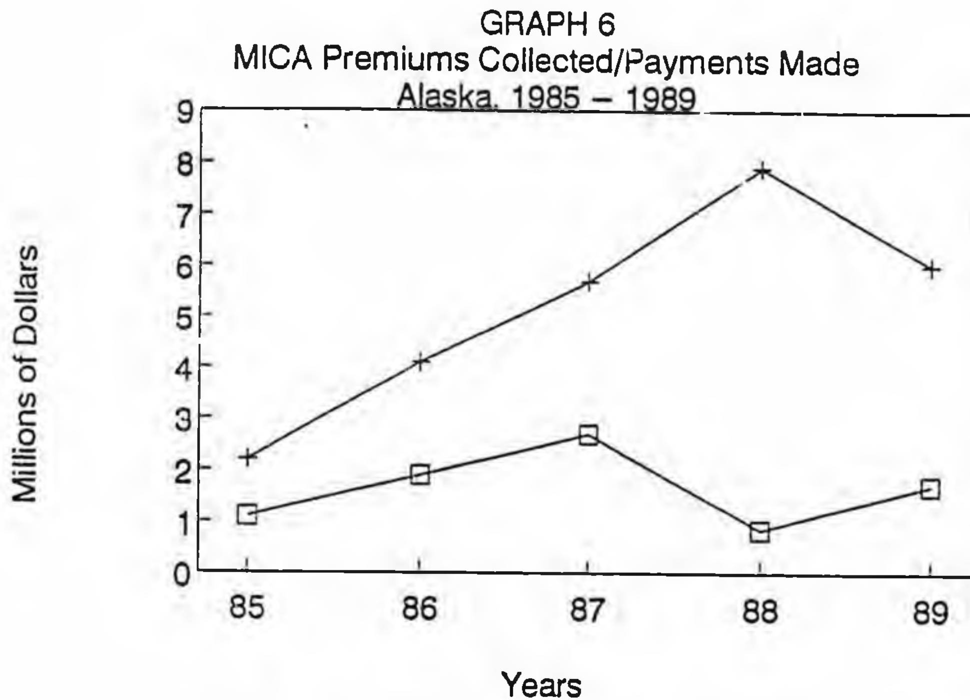


Source: Division of Insurance, Department of Commerce and Economic Development
(91–222GE)

Meanwhile, between 1985 and 1989, MICA alone collected about $5 million a year ($26 million over five years) in premiums from Alaska physicians and hospitals, while the average "loss paid" was about $1.6 million (about $8 million over five years) to satisfy malpractice settlements and verdicts, according to *A.M. Best's Insurance Reports*. This is shown on the list below and on Graph 6.[39]

	MICA Premiums Collected	MICA Loss Paid
1985	$ 2.2 million	$1.1 million
1986	$ 4.1 million	$1.9 million
1987	$ 5.7 million	$2.7 million
1988	$ 7.9 million	$ 840,000
1989	$ 6.0 million	$1.7 million
Total	$25.9 million	$8.2 million
Average	$5.2 million	$1.6 million

[39]Gail de Matteo, A.M. Best Company, personal communication, January, 1992.



MICA Premiums Collected and Payments Made
($ Millions)

	1985	1986	1987	1988	1989
Premiums Collected	2.2	4.1	5.7	7.9	6.0
Payments Made	1.1	1.9	2.7	0.8	1.7

Source: A.M. Best, personal communications, several dates in February 1992.

(91.222GF)

It is important to note that the difference between payments made and premiums collected on Graph 6 does not represent profit alone. Like other businesses, insurance companies have to pay overhead. There are several other factors that complicate comparisons between payments and premiums:

- The typical medical malpractice case takes a long time from event to resolution (the medical malpractice "long tail") and payments in 1985 are for claims filed years earlier;

- Insurance premiums are collected with an eye toward satisfying the estimated payments which will be required in the future for current claims. Adding legal expenses and estimated costs of open

claims, including those not yet reported under "tail coverage" policies inflates the total dollars by severalfold;[40] and

- Payments do not include costs associated with claims, such as lawyer fees, expert witnesses expenses and computer searches.

Future payments cannot be forecast with accuracy because of the uncertainty of court decisions, the delays in investigating and litigating complex cases and "the further imponderables" of appellate reversals of trial court judgments, according to Ron Neupauer of MIEC. "Actuaries spend their professional lives" with these questions, but they are "still only educated guesses," he says.[41] Still, some observers question whether insurers have a large "tail" exposure under claims-made policies.

PHYSICIAN INCOME

Nationwide income studies show that real net income (adjusted for inflation) for U.S. physicians has held fairly steady since 1975 despite increasing malpractice premium costs. Analysts conclude that increased premiums costs are "passed along promptly" to patients.[42]

No study of physician income in Alaska exists. Ray Schalow, executive director of the Alaska State Medical Association, asserts that his organization has tried to collect income information, but that physicians are reluctant to disclose. He adds that most practicing rural Alaska physicians make less money

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[40]Insurers say the reserves they build up reflect actuarial estimates of future liabilities; critics counter that companies earn investment income from these reserves.

[41]Ron Neupauer, faxed communication, February 25, 1992.

[42]The quotation is from Patricia Danzon, who notes an excess of fee elasticities over the level required to fully pass-through the costs of malpractice insurance, and speculates that this may be caused by increased physician time (and charges) per patient encounter, among other factors. "Liability for Medical Malpractice," *Journal of Economic Perspectives*, Vol. 5, No. 3, Summer 1991, p. 62; and "The Incentive Effects of Malpractice: The Effects of Malpractice Litigation on Physicians' Fees and Incomes," *AEA Papers and Proceedings*, Vol. 80 No. 2, May 1990, pp. 122-127.

than most practicing urban physicians.[43] *Medical Economics* reports that the median income of rural U.S. physicians was about $25,000 less than the median income of urban U.S. physicians in 1989.

A continuing annual survey by *Medical Economics* shows the following 1990 median net practice incomes:[44]

- an average of $141,720 for all U.S. physicians;
- a high of $237,120 for orthopedic surgeons; and
- a low of $90,910 for general practitioners.

The magazine reports that U.S. physicians' incomes rose between 1985 and 1990. Among the statistics:

- one out of six U.S. physicians nets at least $250,000, compared to only one in seventeen in 1985;
- three out of four netted $100,000 or more in 1990, compared to only about half in 1985; and
- the annual net increase in physician income from 1985 to 1990 averaged 5.5 percent, compared to the annual inflation rate of 3.7 percent.

The *New York Times* reports that female doctors earn "far less" than their male counterparts at all age and all experience levels. In 1987, male doctors practicing 20 years or more earned an average of $127,200, while comparable women doctors earned $72,800. Among physicians practicing four years or less, men earned $110,600 and women earned $74,000. The newspaper reports that in 1988, roughly one in every six American physicians was a woman. The number of

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[43]Ray Schalow, executive director, Alaska State Medical Association, personal communication, January 14, 1992. Cordova Community Hospital administrator Edward Zeine reported in 1989 that the community's three physicians had dropped their insurance because they could not afford the cost of obstetric and emergency room coverage (Edward Zeine, letter to David Rogers, November 28, 1989). Dr. Ross Brudenell, head of the Alaska State Medical Association medico-legal committee, says he welcomes a physician income study in Alaska (personal communication, February 13, 1992).

[44]Median net income shows income at the 50th percentile; unlike mean or average income, it is not influenced by very large or very small incomes. The figures are based on self-reports by physicians.

male applicants to medical school has dropped 50 percent since the mid-1970s, according to authors Lawrence Altman and Elisabeth Rosenthal.[45]

Medical Economics notes that physicians reported in the 1990 survey that third parties have become more reluctant to pay, volume of business has remained steady (108 patient visits per doctor per week in 1990) and malpractice premiums have dropped slightly. The average work week was 60 hours. The magazine noted that there are large variations for geographic location, specialty and rural-urban settings.

The Institute of Medicine, using American Medical Association data, reports that the average real net income for all U.S. physicians was about the same in 1975 as it was in 1985. Table 9 below compares average physician net income after expenses and before taxes, 1975 and 1985. It also shows average net income for 1990. The table shows, by physician specialty:

- obstetrician-gynecologists, radiologists and psychiatrists as groups maintained their real net income between 1975 and 1984;
- the real net income of internists, pediatricians, family practitioners fell slightly; and
- the real net income of surgeons and anesthesiologists increased.[46]

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[45]Lawrence K. Altman with Elisabeth Rosenthal, "Changes in Medicine Bring Pain to Healing Profession," the *New York Times*, February 18, 1990, pp. 1 and 35.

[46]Data are from American Medical Association, Center for Health Policy Research, 1986, Socioeconomic Characteristics of Medical Practice. They appear in Institute of Medicine, *op. cit.*, Table 6.3, "Physician Income Trends, 1975-1985," p. 105.

TABLE 9
ANNUAL CHANGE IN AVERAGE PHYSICIAN NET INCOME AFTER EXPENSES, BEFORE TAXES, 1975-1985 and 1990: U.S.

Specialty	Average Net Income 1975 ($)	1985 Nominal ($)	1985 Real (1) ($)	Annual Change 1975-85 Nominal (%)	Real (1) (%)	Average Net Income 1990 ($)
General Practice	45.0	77.8	38.9	+5.5	-1.5	90.9
Family Practice	---	---	---	---	---	98.3
Internal Medicine	57.0	101.0	50.5	+5.9	-1.2	110.9
Surgery	68.2	155.4	77.7	+8.6	+1.3	147.9
Pediatrics	44.3	77.1	38.6	+5.7	-1.4	107.8
Ob-Gyn	63.3	122.7	61.4	+6.8	-0.3	202.4
Radiology	75.2	150.8	75.4	+7.2	0.0	Not Avail
Psychiatry	44.8	88.6	44.3	+7.1	-0.1	113.8
Anesthesiology	57.1	140.2	70.1	+9.4	+2.1	184.6
All Physicians	56.4	113.2	56.6	+7.2	0.0	141.7

(1) "Real" income is adjusted for inflation

Source: Institute of Medicine, Medical Professional Liability and the Delivery of Obstetrical Care, 1989; 1990 data: "Doctors Struggle to Stay Ahead of Inflation," Medical Economics, September 3, 1991, p. 123. (91-222TI)

To study how premiums might affect incomes, the institute compared the cost of malpractice premiums with physician gross and net incomes. It reports that in 1986, liability premiums for obstetricians equaled:

- 10 percent of the gross income; and
- 22 percent of net income.

In both cases, the rate for obstetricians was higher than for any other specialty. No comparable statistics exist for the state of Alaska.[47]

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[47]In 1990, the average Alaska physician who delivers babies was willing to pay about ten percent of gross income for medical malpractice insurance. (Mary Pierce, Executive Director, MICA, Letter to Rep. Dave Donley, February 23, 1990.)

The institute also examined amount of premiums as a percent of physician net income by specialty. The results are shown on Table 10. The 1982-1986 total in the last column shows that in all cases, incomes increased despite sizeable premium increases.[48]

TABLE 10
Average Liability Premiums as Percent of Average Net Income, Self–Employed Physicians, U.S. 1982–86

	1982	1983	1984	1985	1986	Increase 1982–86
Ob–Gyn						
Premium	10.8	14.0	19.0	23.5	29.3	171%
Net Income	112.3	118.1	118.8	124.3	135.9	21%
Percent of Net Income	9.6%	11.8%	16.0%	18.8%	21.6%	
Family Practice, GP						
Premium	3.5	4.2	4.6	6.8	7.3	108%
Net Income	71.4	66.9	71.6	77.9	80.3	12%
Percent of Net Income	4.9%	6.3%	6.4%	8.7%	9.1%	
Internal Medicine						
Premium	3.7	4.5	4.9	5.8	7.1	92%
Net Income	86.9	94.6	104.2	102.0	109.4	26%
Percent of Net Income	4.3%	4.8%	4.7%	5.7%	6.5%	
Surgery						
Premium	9.9	11.0	13.3	16.6	21.3	115%
Net Income	128.6	144.3	155.0	155.0	162.4	26%
Percent of Net Income	7.7%	7.6%	10.7%	10.7%	13.1%	
Pediatrics						
Premium	2.9	3.9	3.4	4.7	6.3	117%
Net Income	70.5	70.8	73.7	76.2	81.8	16%
Percent of Net Income	4.1%	5.5%	4.6%	6.2%	7.7%	

Source: Table 6.7, Medical Professional Liability and the Delivery of Obstetrical Care, Institute of Medicine, 1989, p. 109.

(91–222TJ)

[48] Institute of Medicine, *op. cit.*, Tables 6.5 and 6.7

How to Make a Physician Income Survey in Alaska

Specific information about Alaska physician income is not available from the *Medical Economics* continuing survey because the sample of Alaskans is too small to analyze separately. However, Sandy Johnson, research manager and director of the survey, says Alaskans could make such a survey on their own inexpensively. She suggests:

- a double mailing,
- anonymous answers,
- closed questions, and
- incentives

Medical Economics sends respondents a printed copy of findings and offers each one the chance to win dinner for two anywhere in the world. On the second mailing to laggards, the magazine offers to donate to a charity the respondent chooses.

Ms. Johnson suggests patterning an Alaska survey on the magazine's continuing survey so results can be compared nationally. She said she would be happy to advise such a project. She can be contacted at 201-358-7453.[49]

THE SPECIAL CASE OF OBSTETRICIANS

Obstetricians and family practitioners who deliver babies are especially vulnerable to malpractice claims. Currently in Alaska, several large obstetrics claims are pending at one insurance company, but the underwriting executive says this is not unusual.

MIEC's Ron Neupauer says his company currently is holding several large obstetric claims for Alaska physicians and hospitals. He says, "Every insurance company will always have several OB claims pending." Meanwhile:

- **A MICA executive reported that obstetrical claims are the single most expensive medical malpractice claims in Alaska.[50] A MICA study of obstetrics medical malpractice claims processed between 1980 and 1988 shows a total of 31 closed obstetrics claims (more than 3 a year). Of these, 18 resulted in payment to the patient**

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[49]Sandy Johnson, research manager, *Medical Economics*, personal communication, January 16, 1992.

[50]Mary Pierce, executive director, MICA, "Summary of MICA Risk Management Activities," November 21, 1989.

(60 percent or 2 a year). The claims totalled about $3.3 million in settlements or verdicts.[51]

- A 1984 Alaska birth resulted in a $2 million settlement involving an infant which lost both kidneys at a birth attended by a midwife, with an obstetrician nearby who did not assist (reported by the plaintiff's lawyer).

- A 1988 Alaska State Medical Association survey of "potential ob/gyn providers" (obstetricians and other physicians who deliver babies) showed that among respondents, fewer than half provided obstetric care in 1988.[52]

An official with the state Department of Health and Social Services cautions that it would be unwise to "put any stock in those statistics" because the obstetrics situation likely has changed since 1988. No further studies by either the state or the Alaska State Medical Association are available on availability of obstetric care in Alaska.

Anecdotal evidence from state public health nurses indicates that some rural Alaska areas lack obstetrical care; obstetrical care is more available in urban Alaska; and pregnant Medicaid patients may have trouble finding a doctor.

Members of the Maternal and Child Health section of the state Division of Public Health report that three Anchorage obstetricians have stopped delivering babies because of malpractice liability. The head of that section, Anita Powell, says her office foresees problems this summer getting care for pregnant women who are on Medicaid. In the last several months, Alaska public health officials have noted an increase in the number of pregnant women coming to Alaska late in their pregnancies. Several urban obstetricians and family practitioners who deliver babies have already filled their May, June and July Medicaid quotas for Medicaid patients, according to Ms Powell.[53]

In summary, state officials predict:

- pockets of need for rural obstetrical care;

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[51]Obstetrics claims through March 26, 1989.

[52]"Survey of Availability of Obstetric Care for Low-Income Women," Alaska Department of Health and Social Services and Alaska State Medical Association, with 93 percent response rate among 196 family practice physicians and obstetricians.

[53]Urban physicians who deliver babies individually determine what percent of their practice shall consist of Medicaid patients, Ms. Powell says (personal communication, March 9, 1992).

- the ever-present possibility of new need if a rural physician sole provider of obstetrical care leaves his or her practice; and
- a future need for obstetrical care for urban pregnant women on Medicaid.

One state public health nurse, with professional contacts in California, however, says the problem of availability of obstetrical care is not as compelling in Alaska as it is in California.

The National Institute of Medicine reports:

- Alaska in 1985 had 35 family and general practitioners per 100,000 women age 15-44, but only 7 obstetrician-gynecologists for 100,000 women of that age group; and
- only Iowa and South Dakota had a lower rate of obstetrician-gynecologists (6 per 100,000 women age 15-44) and only Idaho matched Alaska's rate of 7.[54]

A Low Rate of Injury but a High Risk of Claims

The Harvard Medical Practice Study found that newborns have a "relatively low risk of suffering" a medical injury, and that incidence of negligence among postpartum mothers and their newborns was "not noticeably different" from that of the entire sample of medical injuries.[55] Despite these statistics, however, obstetricians and other physicians who deliver babies are at high risk for malpractice claims and lawsuits. There appear to be at least three explanations:

- It is difficult to tell if a newborn's injuries were caused by genetic factors, the pregnant woman's behavior or inappropriate medical care before or during birth.
- Serious, lifelong birth injuries are exceedingly expensive to treat and parents or others responsible may file a medical malpractice claim in hopes that a favorable settlement or award could alleviate some of this financial burden.

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[54]Institute of Medicine, *Medical Professional Liability and the Delivery of Obstetrical Care*, Vol. I, National Academy Press, Washington, D.C., 1989, Table 2.1, "Active Nonfederal Physicians and Physician-to-Population Ratios for Obstetrician-Gynecologists and Family and General Practitioners, by State," 1985, p. 16-17.

[55]Harvard Medical Practice Study, *op. cit.*, pp. 6-24 and 6-52.

- A long statute of limitations for a child (the time period allowed for filing a lawsuit after the injury occurs or is discovered) allows for a greater backlog of potential birth-related claims. In Alaska, a minor has until two years past the age of majority to file a lawsuit claiming negligence at birth. Patricia Danzon hypothesizes that technological advances permitting the survival of impaired infants who once would have died may merge with long statutes of limitations to create a transitory swelling of such claims.[56]

MEDICAL LIABILITY AND PHYSICIAN PRACTICES

Physicians report that the threat of malpractice claims and lawsuits has led some to cancel their malpractice insurance altogether, on the theory that patients have less incentive to sue if there is less money to collect. They also say that liability concerns have led them to "defensive" medicine practices.

An Alaska defense lawyer says medical malpractice claims are painful. "Doctors are psychologically affected when someone they worked on and thought they did a good job on, sues them two or three years later," the lawyer says. "It is especially hard where the doctor works hard and gets a bad outcome and is sued, despite doing what the doctor considers his best for the patient. These doctors don't make good defendants. They want to push it out of their minds." That assessment is corroborated by am Alaska surgeon who says he has been the target of seven malpractice claims in 13 years and says doctors react to their first claim as they would to "their first rape."

- One experienced malpractice defense lawyer says Alaska doctors are increasingly reluctant to answer calls for help from the emergency room for fear of exposure to malpractice claims or lawsuits. "A lot of capable doctors are avoiding emergency room patients because emergencies frequently don't have very good outcomes," this lawyer says.

A Definition of Defensive Medicine

Although proof is anecdotal or self-reported, many analysts believe that physicians change their practices to protect themselves from malpractice claims and that these changes may be increasing the cost of health care.

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[56]Robert Litan and Clifford Winston, *Liability: Perspectives and Policy*, The Brookings Institution, Washington, D.C., 1988, p. 105.

"Defensive" or "protective" medicine is defined to include:

- increasing the number of tests or procedures;
- refraining from ordering high-risk tests or procedures;
- changing office procedures (spending more time with patients, keeping more careful records, referring patients for second opinions); and
- withdrawing from high-risk situations (retiring from practice early, avoiding high-risk patients, limiting practices to low-risk specialties).

All commentators agree that certain defensive practices can be deleterious. For example, unnecessary tests can increase the cost of health care or even cause medical injuries. Physicians whose fear of malpractice claims leads them to retire early, refuse to perform high-risk tests and procedures, or refuse to see high-risk patients can inhibit access to care.

But analysts also report that certain practice changes benefit the patient. These include:

- spending more time with patients;
- referring cases to other physicians; and
- keeping better records.[57]

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[57]Inadequate records and lack of time with the patient were the subject of a 1964 Alaska Supreme Court opinion. The surgeon's report should have been dictated immediately after the operation, the court said:

> Instead the report was not dictated until the day following the operation and after appellee had visited and observed appellant at the hospital . . . No mention is made of any problems . . . We know from the pathologist's report that the thyroid gland was enlarged to three times its normal size. It is difficult to believe that this circumstance did not create particular operating difficulties worth mentioning in the report . . . "

The opinion also notes that the patient first met the surgeon, not on the evening before the operation, as she had been promised, but for a few minutes in the operating room just prior to surgery. *Patrick v. Sedwick*, 391 P2d 453 (1964).

Evidence that medical liability is driving physicians to leave practice or refuse to treat certain risky patients or patients with risky conditions is largely anecdotal, according to Frank Sloan of Vanderbilt University and Randall Bovbjerg of the Urban Institute.[58] Patricia Danzon finds "weak evidence" that liability induces physicians to spend more time per patient and no evidence of "defensive ordering of a lot of extra tests and visits." Dr. Danzon cautions that some over-use practices would develop anyway in response to incentives created by extensive health insurance. (She says that with full fee-for-service insurance, the patient has the incentive to demand, and the physician the incentive to provide, any test or procedure that potentially benefits the patient, no matter how small.) Dr. Danzon wonders if the trend encouraging physicians to control costs, such as health maintenance organizations, will reduce the incidence of defensive medicine.[59]

Physician Response to a Claim

In a recent survey of Michigan physicians, 65 percent of respondents said they had experienced at least one lawsuit and, of those, 11 percent said they used more alcohol or self-medicated with narcotics, anxiolytics or antidepressants as a result. The majority of Michigan physicians who had experienced a malpractice lawsuit said their ability to care for patients had been significantly altered. Only 7 percent said they had talked about their experiences with a mental health professional. No similar survey has been released in Alaska.[60]

Other observers say the presence of medical liability undermines patient-physician trust. This trust is important because, in the words of health care economist Victor Fuchs, "When you are sick and scared, you want to see your doctor, not your lawyer or your health economist." Without two-way trust, doctors fear patients will file malpractice claims willy nilly and patients suspect doctors of passing on the high cost of premiums, making unsound medical decisions to avoid liability, or refusing to see them altogether for fear of suits. This sets the stage for misunderstanding, anger and a lawsuit, as well as bad medicine.

Between Scylla and Charybdis

Competing pressures can place today's physician between the Scylla of changing medical care and the Charybdis of threatened malpractice claims. Edward Hirshfeld of the American Medical Association says courts today hold a

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[58]Sloan and Bovbjerg, *op. cit.*, p. 32 and 33.

[59]Litan and Winston, *op. cit.*, p. 111.

[60]Bruce Wenokur and Linn Campbell, *op. cit.*

physician liable if an injured patient did not receive needed care. Yet, at the same time, health insurers and other payers pressure the physician to keep costs low by avoiding unnecessary services. Mr. Hirshfeld concludes that courts tend to focus on whether withheld services would have ameliorated the patient's illness or injury, without explicitly considering whether the services would have achieved a sufficient benefit to justify the expense.[61]

SUGGESTIONS FROM LAWYERS

One Alaska lawyer says that medical malpractice claims mirror the economy. In a recession, the number of claims in Alaska goes up, in good times, the number goes down. Another lawyer says claims fall when the medical profession polices itself. Whatever the reason for these claims, medical liability law is good business in Alaska. There are Alaska lawyers on both sides of the malpractice fence who say their practice consists of nothing but medical liability cases, and a number of others who devote much of their practice to this field.

In this section, Alaska plaintiff and defense lawyers suggest what the legislature might do to avoid the malpractice liability "crisis" predicted for the next few years by medical malpractice scholars. Not all the lawyers we contacted responded; some were out of town, some did not return phone calls. Several asked for anonymity so they could speak candidly. Accordingly, we have identified all by type of practice only.

Except for lists of states which try some solutions suggested by the lawyers, this section contains only the lawyers' responses to the question, "How would you improve the medical malpractice liability situation in Alaska?" It includes no analysis of the merits of the suggestions. The suggestions follow.

Transfer High-Risk Pregnant Women From Bush to Urban Areas

A plaintiff lawyer urges transferring some pregnant women to Anchorage six weeks before the baby is due. "If we speak honestly, without all the politics, high-risk women should not be having babies out in the Bush. If Mom smokes a pack of 'butts' a day or drinks or does drugs or has medical problems, she should be delivered in Providence where the first 20 minutes of her baby's life can mean the difference between spending life as a vegetable or as a normal person," this lawyer says. He adds, "These cases happen all over Alaska--in Kenai, in Seward, in the Bush, in Juneau."

The lawyer suggests a program similar to federal pre-maternal homes in Alaska. He would fund it with a "very small percentage" of money from the Longevity

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[61]Edward Hirshfeld, "Economic Considerations in Treatment Decisions and the Standard of Care in Medical Malpractice Litigation," *Journal of the American Medical Association*, Vol. 264, No. 15, October 17, 1990, p. 2004.

CORRECTION

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physician liable if an injured patient did not receive needed care. Yet, at the same time, health insurers and other payers pressure the physician to keep costs low by avoiding unnecessary services. Mr. Hirshfeld concludes that courts tend to focus on whether withheld services would have ameliorated the patient's illness or injury, without explicitly considering whether the services would have achieved a sufficient benefit to justify the expense.[61]

SUGGESTIONS FROM LAWYERS

One Alaska lawyer says that medical malpractice claims mirror the economy. In a recession, the number of claims in Alaska goes up, in good times, the number goes down. Another lawyer says claims fall when the medical profession polices itself. Whatever the reason for these claims, medical liability law is good business in Alaska. There are Alaska lawyers on both sides of the malpractice fence who say their practice consists of nothing but medical liability cases, and a number of others who devote much of their practice to this field.

In this section, Alaska plaintiff and defense lawyers suggest what the legislature might do to avoid the malpractice liability "crisis" predicted for the next few years by medical malpractice scholars. Not all the lawyers we contacted responded; some were out of town, some did not return phone calls. Several asked for anonymity so they could speak candidly. Accordingly, we have identified all by type of practice only.

Except for lists of states which try some solutions suggested by the lawyers, this section contains only the lawyers' responses to the question, "How would you improve the medical malpractice liability situation in Alaska?" It includes no analysis of the merits of the suggestions. The suggestions follow.

Transfer High-Risk Pregnant Women From Bush to Urban Areas

A plaintiff lawyer urges transferring some pregnant women to Anchorage six weeks before the baby is due. "If we speak honestly, without all the politics, high-risk women should not be having babies out in the Bush. If Mom smokes a pack of 'butts' a day or drinks or does drugs or has medical problems, she should be delivered in Providence where the first 20 minutes of her baby's life can mean the difference between spending life as a vegetable or as a normal person," this lawyer says. He adds, "These cases happen all over Alaska--in Kenai, in Seward, in the Bush, in Juneau."

The lawyer suggests a program similar to federal pre-maternal homes in Alaska. He would fund it with a "very small percentage" of money from the Longevity

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[61]Edward Hirshfeld, "Economic Considerations in Treatment Decisions and the Standard of Care in Medical Malpractice Litigation," *Journal of the American Medical Association*, Vol. 264, No. 15, October 17, 1990, p. 2004.

Bonus program. He says such a plan would cut down on big obstetric malpractice settlements and verdicts.

Regulate Insurers

A plaintiff lawyer urges the legislature to regulate liability insurance companies. He says that liability crises are the result of underwriting problems and that it is up to the Alaska legislature to hold insurers accountable for:

- how they invest their reserves;
- what they disclose about profits; and
- how they set their rates.

He says the legislature should require prior rate approval rather than continuing the system in place today in which insurers set the rates, subject to state disapproval. "This system doesn't do the job," he says. Until we get some "forward-looking" legislation which requires disclosure, as well as an adequate number of actuaries to back it up, the system is in for more trouble, he says.

Another plaintiff lawyer adds, "And you know why insurers don't want the information out there, don't you? It's because the information doesn't substantiate their position."

Modify Prejudgment Interest

A defense lawyer says a large verdict plus accumulated prejudgment interest could exceed a physician's insurance limits and put the physician into bankruptcy. Alaska law requires interest on judgments paid at 10.5 percent a year from the date a defendant received written notification that the injury has occurred and that a claim may be brought (AS 9.30.070).

Under the state's statute of limitations, when adults win malpractice claims, prejudgment interest can accrue for not more than two years prior to filing. The statute of limitations for children, however, is two years after the age of majority. For a case involving a child injured at birth, prejudgment interest could accrue at 10.5 percent per year from date of delivery through date of filing. Most children's cases are filed quickly, Alaska malpractice experts say. A MICA study, for example, shows that through 1986, medical malpractice claims with payments of more than $100,000 involving infants were

brought within two years of the date of the alleged injury.[62] That is not always the case, however, as the following two examples show:

- a lawsuit on behalf of a child born in 1970 with cerebral palsy was not filed until the child was 11;[63]

- a recent birth-related claim involved a 13-year-old girl. The defense lawyer in that case said the threat of 13 years of prejudgment interest "puts you under the gun to settle, and we did--for $600,000."

Another defense lawyer says prejudgment interest, if it is allowed at all, should fluctuate with current interest rates. He says the current system actually allows the plaintiff to get interest on money lost in the future. "The plaintiff ought not to be able to make money," he says.

Protect Physicians Who Provide Emergency Care

A defense lawyer says that Alaska physicians are avoiding calls for help from the emergency room because emergency care is apt to have a bad result. Emergencies are bad injuries, and bad injuries can have bad outcomes, the lawyer says. This can be especially true when the emergency involves obstetrics, which is already a high-risk field.

Some states have set up plans to protect physicians who help in emergencies or provide care to certain obstetric patients (see part two for details):

- Delaware, North Carolina and Virginia limit the liability of health care physicians who offer charity obstetrical care to indigent patients or to women who go to the emergency room for delivery ("drop-in" deliveries). The Virginia law exempts the physician from liability even if the physician received payment for the service, according to the Southern Regional Project on Infant Mortality. Recent California bills would exempt a physician and surgeon from liability for emergency room care rendered on an on-call basis at a hospital emergency room (AB 1813, 1991); would exempt a provider who renders assistance without compensation (AB 117, 1990); and would exempt a provider from liability for providing voluntary medical care in a shelter (AB 828, 1991).

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[62]Joyce Wainscott, "Claims Evaluation," March 28, 1988.

[63]Rodman Wilson, M.D., "Alaska's Medical Advisory Panel System for Malpractice Lawsuits," unpublished paper, February 13, 1983.

- Montana exempts from liability physicians who give instructions to emergency medical technicians (HB 938, Ch. 304, 1991); North Dakota exempts those who give voluntary care at a free clinic; Texas indemnifies a member of a medical staff or a student for judgments or settlements resulting from charitable care (SB 557, 1991).

Help Rural Physicians Who Deliver Babies

A plaintiff lawyer says the state should protect physicians who deliver babies in rural areas not covered by federal hospitals. He says these physicians deliver fewer babies than their urban colleagues and, as a result, make less money on the procedures but pay the same medical malpractice premiums. Another plaintiff lawyer urges the state to find rural physicians who cannot afford premiums and "if it is in the public interest," help them out. He suggests:

- paying a higher Medicaid reimbursement rate to rural doctors who deliver babies; or

- paying the difference between malpractice premiums with and without obstetrics for rural physicians.

A state insurance official says the state should ask doctors for proof that they cannot afford their premiums. "I want to see tax returns before giving out money," he says. A plaintiff lawyer agrees. He asserts that Alaska orthopedic surgeons, for example, take home $700,000 a year and "with that kind of income, who cares if their premiums are $90,000?" Physicians delivering babies in remote areas are a different matter, this lawyer says.

Several states have cobbled together subsidies for malpractice premiums for doctors in certain specialties or geographic areas. They include (see part two for details):

- Under North Carolina statutes, the state funds local health departments which, in turn, subsidize the malpractice insurance premiums of physicians or certified nurse midwives with whom they contract for the provision of obstetrical services. The subsidy is the difference between the physician's insurance with or without obstetrics or a dollar amount ($6,500) per year. The purpose of this system is to keep rural physicians in the areas in which they are already practicing. The law was passed in 1988 and in 1991, the legislature increased its funding. This is the Rural Obstetrical Care Incentive (ROCI) program.

- Missouri has extended a state liability fund to include physicians who provide obstetrical or pediatric care with "minimal" compensation (85 percent of the Medicaid fee) or no compensation while under contract with the local health department. This

relieves the participating physician from buying long "tail" insurance to cover cases which might be filed under the state's statute of limitations for children. Like Alaska, Missouri's statute of limitation allows children's cases to be filed until after the child reaches the age of majority.

- Montgomery County in Maryland hires obstetrical providers as part-time county employees and assumes liability for the care of Medicaid-eligible and indigent patients.

- Texas assumes indemnity for a practitioner with a caseload of ten percent or more in charity care. The state assumes the first $100,000 in damages per occurrence for any obstetrical claim and the first $25,000 in damages per occurrence for other claims. On the other hand, patient compensation funds operating in some states ask the participating physician or the insurance company to pay the first $100,000 of a settlement or verdict and accept responsibility for the rest (up to a cap).

Gather Data on Trends

A plaintiff lawyer and observer of the medical malpractice political scene for several years says lack of historical data on claims and payments is a "terrible problem." It is impossible to pass good medical liability laws without good data, he says.

Commenting on a state law requiring physicians since June 1990 to report payments made on their behalf for malpractice claims, one lawyer warns that physicians will no longer be willing to settle "nuisance" suits. He says he has already noticed this trend. The result will be more trials and more clogging in the system, he says.

Fine Practitioners Who Fail to Report Dangerous Practices by Colleagues

A plaintiff lawyer suggests levying "big-time" fines against physicians who work with, or assist, negligent or dangerous colleagues but fail to report them to oversight boards.

Do Away With the Expert Advisory Panel

A defense lawyer says Alaska should do away with its expert advisory panel, which since 1978 has been examining medical malpractice lawsuits for evidence of "unskillful" medical care. The panel usually is correct about fault, this lawyer says, and it does a good job of screening out nonmeritorious cases handled by inexperienced lawyers, but experienced plaintiff counsel ignore it.

(One plaintiff lawyer, with a high win record, says that the panel has returned a "fault" opinion in every medical malpractice case he has taken.)

A defense lawyer says the system discourages communication between the parties and the panel. Once the panel comes to a decision--which one lawyer says may be ambiguous and poorly written--years may pass before the case goes to trial and, because panel members can be examined at trial, it is illegal and unethical for lawyers to talk to them about the case. Worse, says this lawyer, is when new issues may be injected into the case that the panel did not consider. The lawyer says he was unable to use the panel's finding at a recent trial because so much had happened in the case since the panel's decision. "The whole thing was well intended but doesn't work," the lawyer says.

A plaintiff lawyer says the expert advisory panel system increases his costs. He says the three panel members are viewed as three experts during trial, forcing him to counter with at least three expert witnesses of his own, which he says can be an expensive proposition when it involves internationally known people.

Finally, doctors say it is hard to find physicians to serve on the panel. One member of the Alaska State Medical Society says that it was impossible to find physicians to serve as experts in about 25 to 30 of the 400-plus lawsuits filed before the expert advisory panel since its beginning.

Encourage Nurses to Report Dangerous Practices

One plaintiff lawyer says that, "if we really want to improve health care in Alaska," legislators should pass a whistle-blowing statute giving nurses anonymity and immunity when they report dangerous practices by physicians and facilities. "Nurses are the ones who really care about people, you know," this lawyer says. "They are the ones who are with you when you die."

Strengthen State Enforcement Boards

A plaintiff lawyer suggests dramatically strengthening the enforcement power of the state board which oversees medical practitioners. He says information about every doctor or hospital who is accused of malpractice, or even of those who pay settlements, is of limited use to the general public, but "of great use" to the state oversight boards who are responsible for stopping dangerous practitioners.

Don't Throw Out the Baby with the Tort System Bath Water

A plaintiff lawyer says most of the tort reforms made by the Alaska legislature have not reduced the costs associated with medical liability. Joint and several liability and caps on recovery have reduced the number of claims, but

they have had no effect on lawyers' fees, for example, he says. The lawyer describes current joint and several liability as "a mess," because it forces litigation against all parties in a case, rather than against a primary party. Another plaintiff lawyer says any more tinkering with tort reform will "emasculate" victim's rights.

A defense lawyer finds Alaska's tort system expensive and full of loopholes, despite the legislative tinkering. Another agrees, but says the fault system, flawed though it may be, can work. It is not so inefficient that it should be dismantled, he says. "I am adamantly opposed to federal solutions that envision a system that works like workers' compensation," the lawyer says. "The only people who like that solution are the insurance companies, who will get rich from it."

Create Universal Health Insurance

One lawyer who has represented medical malpractice plaintiffs suggests that one big reason patients file lawsuits against doctors is to pay for the enormous expense of medical care. "What I am saying is, if you had universal health insurance, if these people weren't facing hundreds of thousands of dollars of past and future medical bills, you wouldn't have so many lawsuits," the lawyer says.

The experience of one Alaska physician corroborates. An obstetrics patient who delivered a baby with expensive medical problems contacted a malpractice plaintiff lawyer and later told the physician, "I'm not mad at you, but I need money to pay the medical bills." The doctor says the patient subsequently moved to Canada where her child's medical bills are paid by a national health care program.

Try Alternatives to the Tort System

A lawyer who has observed medical malpractice from a statewide perspective says he is convinced Alaska must find alternatives to the tort system for medical liability disputes. "We need to think seriously about mediation, no-fault, limited no-fault and accelerated compensation events," the lawyer says "and get away from tinkering with the tort system at the expense of the victim." Another lawyer-observer of the statewide scene comments, "Tort reform isn't going to do it. We had it in '76, we had it in '86. It didn't work then. Why should it work now?"

A malpractice defense lawyer agrees. Summing up what he calls a Pandora's Box of ineffective tort reform statutes and expensive loopholes (including joint and several liability, economic caps and the statute of limitations), this lawyer says:

> "I may be talking myself out of a job, but any system which allows lawyers and claims adjusters to get 65 to 70 percent of the money is not a system made in heaven. Why should one patient with [an experienced] lawyer get $2 million while another [with an inexperienced lawyer] gets $200,000--or nothing? Why should cases take three years to plow through the court system? There are a lot of things that could be clarified to make the system quicker, cleaner and more expeditious."

The lawyer suggests that legislators sit down with Alaska plaintiff and defense lawyers in a roundtable discussion to talk about the effects the state's tort reforms of the last two decades have had on real life medical malpractice litigation.

LOOKING FOR A CURE

The malpractice liability malaise has flared up three times since the late 1960s, forcing policy makers in Alaska and the rest of the nation to rush to the bedside in crisis. Despite their best efforts, they have produced no cure.

The focus of the 1970s and 1980s was on the physician, while the focus of the 1990s is on the patient who pays the rising costs of medical liability. What 20 years ago was a "crisis of affordability and availability" for the physician, has become a "crisis of rising health care costs" that is putting medical care out of reach of a growing number of Americans. In the words of Victoria Rostow, director of the definitive Institute of Medicine study of the effects of malpractice liability, it is clear that the malady not only has "defied treatment," but has been "exacerbated."[64]

A Tangle of Contradictions

Medical liability in Alaska and elsewhere is an intricate tangle of contradictions. For example:

- **High-tech** medicine does great good, but it also does great harm. Technological advances announced by researchers and hailed on public television and Cable News Network, lead patients to expect perfect babies, miraculous medical outcomes, every time. But the technology that saves an injured low birthweight newborn carries

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[64]Victoria Rostow and Marian Osterweis, "Medical Professional Liability and the Delivery of Obstetrical Care," *New England Journal of Medicine*, Vol. 321 No. 15, p. 1057.

with it the risk of a malpractice claim against the physician who may have caused the injuries in order to save the life.[65]

- Few negligently injured patients file malpractice claims. But some doctors, wary of the threat of a malpractice lawsuit and trial, have withdrawn from high-risk patients and procedures, leaving patients without adequate medical care.

- Physicians pass the cost of malpractice insurance premiums on to patients by increasing fees. These fees often are paid by private or public health insurance bought by patients, employers or taxes. In a byzantine arrangement of premiums, the health insurance bought by a healthy person helps pay the malpractice insurance premium that protects the doctor from the expense of a malpractice claim filed by the patient.

The Liability System: Safety Net or Lottery?

Traditionally, policy makers have relied on the tort system to recompense negligently injured patients, but that system today is being characterized less as a "safety net" than a "lottery" in which a few big winners are subsidized by the many.

Tort System as Safety Net

Ralph Nader calls the tort system a pillar of American democracy and says that to lose it would be to lose a "fountainhead of civilized values." The tort system is an essential dispute resolution mechanism, which, although underused by injured people, has adapted to the hazards of modern technology because rulings by juries and judges are driven by the evidence, he says in a recent article in *Trial*. Speaking for those who see the tort system as a safety net, Mr. Nader writes that the current system:

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[65]Anchorage malpractice defense attorney James Delaney, Jr. made similar comments in 1967:

> "The public has come to expect miracles in every case, under any circumstances because they have read of so many medical miracles that have actually been accomplished. The threshold of medical knowledge is advancing rapidly; and new techniques that promise cures where none were available before also involve risks that did not have to be faced when the physician merely needed to tell the patient that nothing could be done for him." James Delaney, "Malpractice Lawsuits in Alaska," *Insurance Counsel Journal*, July, 1967, p. 410

- compensates victims,
- deters misconduct and punishes wrongdoers,
- prevents further injury to others,
- forces public disclosure of information on dangerous practices, and
- provides a judicial forum where responsibility can be established for perpetrators of trauma and disease.[66]

Tort System as Lottery

Among the critics who view the current medical liability system as a lottery, however, are those who note that:

- almost no injured patients are compensated through the tort system without first filing a malpractice claim, something 98 percent of negligently injured patients do not do;
- a substantial portion of patients file claims for outcomes in which negligence may not have played a role, and some are compensated;
- to protect themselves from malpractice settlements and verdicts, physicians pay many thousands of dollars for malpractice insurance premiums and quickly pass these costs on to their patients. But a physician with high losses pays no more in premiums than the physician with no losses. The insurance company, not the doctor, makes the payment after settlement or verdict;
- malpractice defense lawyers say they take to trial "slam dunk" cases they know they can win. But publicity from a trial can pillory the reputation of the doctor. The majority of cases settle and remain out of the public eye; and
- malpractice claims cost both plaintiff and defendant time, money and psychic energy.

The most careful physician can have a momentary slip in concentration (just as the same physician--and all of us--can lapse while driving or paying the bills

[66]Ralph Nader and Joan Claybrook, "Preserving a Pillar of Our Democracy: The Tort System Protects the Injured," *Trial*, December 1991, pp. 45-49.

or fixing the toaster). But, as the Harvard Medical Practice Study shows, when a physician's attention wanders, a patient may be hurt, and often severely.

Whether a doctor "pays" monetarily for negligence depends on the nature and severity of the injury. Sanction is random. A meticulous doctor whose knife slips once while he saves a patient's life in a heroic, emergency maneuver may pay millions, while another doctor whose more frequent carelessness inflicts minor damage (rashes, numbness, persistent headaches) may never be pursued.

Meanwhile, severe medical injuries cause real financial and emotional costs, whether the injury was caused by chance or by carelessness, by the momentary lapse of a scrupulous and caring expert or the slipshod error of an incompetent.

An Alaska Insurance Executive: "Not the American Concept of Justice"

In 1989 and 1990, an Alaska House Liability Task Force, tired of relying on anecdotal evidence, collected the best information available on liability in Alaska and other states. The task force met twice, with no consensus on most issues. Among the written comments was the following from Mary Pierce, former executive director of MICA, in a letter dated March 29, 1990:

> Is, in fact, justice being done under the current system? I feel that the task force was presented with evidence to the contrary.
>
> First of all, plaintiff attorney members of the task force testified that they would not pursue medical malpractice cases against a health care practitioner who was uninsured. They also said that they turned away all but the most compelling cases. This leads me to believe that there are citizens of the state of Alaska who have been legitimately injured and who have no recourse for recovery under the current system.
>
> We have also had information presented to us that clearly proved the opposite exists: some victims are overcompensated. My feeling is that this is not the American concept of true justice.

David Rogers, special counsel to the task force, reported that although it could not come to a consensus on most of the issues it tackled, the task force found agreement on two "critical points" (memorandum of June 17, 1990):

> (1) There is need to further consider alternative dispute resolution mechanisms which may represent at least a partial solution to many of the problems identified by critics of the present system including: unreasonable

delay, excessive costs of litigation, unpredictability and fairness of compensation and lack of access to the court.

(2) There is a need for further information and analysis of issues concerning the insurance industry and regulation of professional conduct.

CONCLUSION

Roughly 1 in every 100 hospital patients is injured by medical negligence, but fewer than 2 percent file a medical malpractice claim. This phenomenon, reported in the 1980s, was overshadowed in state legislatures by other pressing medical liability concerns, such as the mounting costs of malpractice premiums and payments. As a result, policy makers caught up in the struggle to solve obvious emergencies, were unaware of the far more widespread but less apparent cost of injuries caused by medical negligence.

The tort system is designed to allow the wrongfully injured who experience great pain or are disabled for life to have their day in court, to at least recover money damages for the harm imposed by someone else's negligence. In the words of Ralph Nader, the system serves the public in five ways: it compensates victims, it deters misconduct and punishes wrong-doers, it prevents further injury to others, it provides public disclosure of information on dangerous practices, and it provides a judicial forum where responsibility can be established for perpetrators of trauma and disease.

But does the tort system work this way for the estimated 400 or so Alaska patients who every year are injured by negligent hospital care? As this report indicates, in Alaska today not all negligently injured patients are compensated; not all negligent practitioners are deterred or punished; public disclosure of information on negligent practitioners is minimal; and only a fraction of cases--the surest cases for the defense--survive to a judicial forum. All other malpractice claims are dropped or settled, sometimes for large amounts of money, far out of the public eye.

Part two of this report will consider alternative dispute mechanisms in the medical liability arena contemplated or underway in other states.

ALTERNATIVES TO TORT REFORM

Part two of this report describes policy alternatives for those considering steering medical malpractice issues away from the tort system. Most of these options were conceived after the storm and fury of the malpractice "crisis" of the last two decades that sent physicians, lawyers and insurers to every capitol building in the nation in a struggle to shape the tort system into an image that suited their interests.[67]

The list is not comprehensive, for new ideas and variations on the old are ubiquitous. It is provided as seed for those who wish to cultivate alternate notions that might, with luck and the proper nurture, dissolve the clouds of yet another "crisis" that observers close to the scene see gathering on the horizon. In the words of a Tillinghast/Towers Perrin principal actuary, taking on the role of a cassandra:[68]

> "It is extremely unlikely that med[ical] mal[practice] will start behaving 'properly' in the future. . . Instead, because of the very significant potential for increases in the number and size of claims, it is likely that the line will again experience sudden shifts in cost levels. Thus, while the line is fairly stable now, it will be surprising if the line remains so over the next ten years. This complex, risk-laden, emotionally charged game of chance will be closely watched and--one hopes--cautiously played in the foreseeable future."

Included in the following list of policy options are descriptions of state programs which put versions of the approaches to work and, when available, assessments by experts of the success or failure of these state programs:

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[67]A commentator for *Business Week* in 1987 called the situation a "depressingly familiar guerrilla war," with "patients as the casualties." Doctors blame the legal system; lawyers blame "incompetent" physicians and "greedy" insurers (August 3, 1987, p. 28). Carrying on the name-calling, a lawyer told the *Indianapolis Star* in 1990 that during Indiana's 1975 legislative deliberations, "[t]he entire House chamber was full of doctors--yelling, screaming . . . [I]t was the damndest thing you've ever seen." Joseph T. Hallinan and Susan M. Headden, "Malpractice Laws Stacked Against Victims: Doctors, Insurance Companies Reap Biggest Benefits," June 26, 1990, p. 1 (cited by Eleanor Kinney and William Gronfein, "Indiana's Malpractice System: No-Fault by Accident?" *Law and Contemporary Problems*, Vol. 54, No. 1, Winter 1991).

[68]Gail Tverberg, "Why is Everyone Talking About Med Mal?" *Contingencies*, January-February 1992, p. 37.

- The American Medical Association's Administrative Plan,
- Limited No-Fault Plans,
- Subsidies and Similar Devices,
- Practice Parameters,
- Patient Compensation Funds,
- No-Fault Plans,
- Accelerated Compensation Events,
- Experience Rating,
- Mediation,
- Immunity, and
- Options Chosen by the Southern Legislative Conference.

THE AMERICAN MEDICAL ASSOCIATION'S ADMINISTRATIVE PLAN

Under the American Medical Association (AMA) plan, claims would be decided not by a court but by a board of hearing examiners in administrative hearing, with the right of appeal to a state appeals court. Appointed lawyers would be free and fees of private counsel would be set by statute. The standard of care would focus on whether the challenged action fell within a "range of reasonableness"; recovery would be permitted if the physician's negligence "contributed" to the cause of injury; the perspective of the "reasonable patient" would determine whether informed consent was adequate; and non-economic damages would be capped.[69]

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[69]Information on this section is from Carter G. Phillips and Paul E. Kalb, "Replacing the Tort System for Medical Malpractice," *Stanford Law and Policy Review*, Fall 1991, pp. 210 ff.; Kirk B. Johnson et al., "A Fault-Based Administrative Alternative for Resolving Medical Malpractice Claims," *Vanderbilt Law Review*, October 1989, pp. 1366-1386; and "The AMA Tries Its Hand at Malpractice Reform," *Medical Economics*, April 18. 1988, p. 210; and Harris Meyer, "Alternative Malpractice Plan Moving in States," *American Medical News*, Vol. 34, No. 36, September 23, 1991, p. 3.

A Georgetown University study concludes that the system might cut the time needed to resolve claims by half and the cost of resolving claims by one-quarter per case.[70]

Legislation to create an administrative system based on the AMA proposal is pending in **VERMONT** and **MICHIGAN**. The Vermont bill is probably moribund. The Michigan bill is being changed to an arbitration model. Meanwhile, an actuarial study in **UTAH** in 1990 discouraged that state from trying the plan, according to an article in the *American Medical News*, an American Medical Association publication. Using actual closed claims and hospital reports to simulate the outcome of an administrative system, the Utah study found medical malpractice insurance premiums would double in the worst case scenario and stay about the same in the best.

- The **VERMONT** bill (H 8733) would provide for a three-member medical negligence compensation board with exclusive jurisdiction over malpractice cases. It would employ claims reviewers and hearing officers, but it would not handle professional discipline. This bill is overshadowed by H 733, a Health Care Reform system introduced by Governor Howard Dean, who is a physician. The governor's bill includes a modified version of the AMA plan, but Jack Cashman of the state medical society says it is beginning to resemble a screening panel. Mr. Cashman says the original bill ("the AMA plan with a Vermont flavor") will die this spring. He said the governor's bill passed the state house recently but is facing a "tough road" in the senate.[71] Vermont medical malpractice claims frequency and premium costs are low compared to other states, according to *American Medical News*.

- The **MICHIGAN** bill would have created a three-member panel. Tom Wolff of the Michigan State Medical Society said Michigan people "aren't too happy" about the bill's proposed new bureaucracy. He said there is movement in the legislature to rewrite the bill to shore up the state's arbitration plan by making it harder to opt out of arbitration. He said the state is considering more tort reforms (capping non-economic damages at $250,000; lowering the child statute of limitations from 13 years to 8). The legislature is also interested in requiring carriers to get prior approval

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[70]"Medical Liability and Access to Obstetrical Care: Can Alternatives to the Tort System work?" Southern Regional Project on Infant Mortality, 1991, p. 24.

[71]Jack Cashman, membership services, Vermont State Medical Association, personal communication, March 7, 1992.

before they can raise rates, Mr. Wolff said.[72] The bill is sponsored by Senator Joe Schwarz and Representative Roland Niederstadt.

The Mechanics of the AMA Plan

The plan includes four stages: review, hearing, written opinion and the right to appeal.

Review

In the first stage, the patient would file a form with a state board governed by seven full-time members (including two or three physicians) selected by the governor and subject to legislative approval. The claim would be reviewed by trained reviewers, who would send claims with merit on to a second review, this one by qualified physicians authorized to interview patients and providers. The parties would be sanctioned if they refused a settlement offer that was determined later to have been reasonable.

Hearing

In the absence of settlement, the claim would move to the second stage: a hearing conducted like an informal trial, presided over by an administrative law judge. Claimants would have the right to be represented by counsel. Fees of private lawyers would be limited by statute. Patients with claims deemed legitimate would be offered free legal counsel.

Administrative Law Judge's Decision

The judge's written decision (issued within 90 days) would determine liability and damages. If neither side appealed the decision, the board would review the judge's decision and certify it as binding precedent for future cases. If the board refused to bind the decision as precedent, the decision would bind the parties in the current case only.

Right to Appeal

The losing party would have the right to appeal to a three-member panel of the board which would adopt, modify or reject the judge's opinion. The board would report any finding of liability to a state clearinghouse and require the

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[72]Tom Wolff, Michigan State Medical Society, personal communication, March 7, 1992.

physician to pay damages within 30 days. At the fourth stage, the patient or practitioner could appeal any adverse board decision to the state appellate court, which would decide whether the board acted arbitrarily or capriciously or abused its discretion.

Other Proposed Changes

The AMA proposal would make the following changes in the rules for determining medical liability. The changes would:

- replace the current standard of care (today usually based on customary practices in the community) with one of reasonableness (the standards of a prudent and competent practitioner working under similar circumstances);
- allow patients to recover damages if the physician's negligence contributed to the injury--even if the physician were less than 50 percent at fault--apportioning damages by the degree of fault;
- allow collateral sources of payment to reduce the damage award; allow payments in periodic installments for awards exceeding $250,000; and cap noneconomic damages, including pain and suffering at $700,000 (with the level dependant on the average annual wage in the state, as well as the life expectancy of the patient before the injury); and
- use the perspective of the reasonable patient to measure the physician's disclosure of information in obtaining informed consent.

An Information Clearinghouse

The board would establish an information clearinghouse to collect mandatory reports from hospitals (on substandard performance by physicians), from insurers (on denial of coverage), from courts (on criminal conviction of physicians), and from physicians (on colleagues suspected of incompetence or impairment). The clearinghouse would also collect data on settlements or awards, as well as information on disciplinary actions in other states.

PRO: Advocates say the proposal simplifies the process; provides free legal representation for claimants; allows collateral sources to pay most small claims; is fair because it uses an experienced, dispassionate judge rather than a jury; and provides a corpus of written decisions. They say the system would be more likely to identify negligence

because it would increase the number of claims filed and resolved, and because it would create a clearinghouse of information about substandard practice. It would control costs through caps, collateral source payments, periodic payments and by compensating only patients injured by negligence.

CON: Critics note the proposal includes no funding source (particularly none from physicians); that it threatens the right to a jury trial; that it requires a whole new administrative structure; and that injuries from medical care can be expensive whether or not they are caused by negligence. In Vermont, critics say lawyers would not take cases for low hourly rates, according to *American Medical News*.

LIMITED NO-FAULT

A limited no-fault plan compensates patients for certain medical injuries, whether or not there was negligence. Currently two states offer limited no-fault compensation for birth-related injuries. The purpose is to take catastrophic obstetrical injuries out of the tort system and make care more accessible and premiums more affordable.

The limited no-fault concept for birth injuries currently operates in **VIRGINIA** and **FLORIDA** and proposals have come before the **NEW YORK** Assembly and the **NORTH CAROLINA** legislature. Meanwhile, the National Vaccine Injury Compensation Program was established by Congress in 1986. For a variation on the theme, see the discussion of Accelerated Compensation Events. This section discusses the limited no-fault concept in general, with references to how it is set up in the states.

The Florida and Virginia plans exclude congenital or genetic causes of injury, but no specific mention is made of injuries which occur at a birth made high-risk by the pregnant woman's behavior during pregnancy (e.g., use of alcohol or drugs).

- The nation's first birth-related injury compensation plan, the **1987 VIRGINIA** law, was modeled on workers' compensation.[73] The law was passed after a Virginia jury awarded more than $8 million for birth injuries. Despite a legislative cap on malpractice

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[73]Virginia Birth-Related Neurological Injury Compensation Act, Code of Virginia 38.2-5000 to 38.2-5021.

damages, the award was upheld by a federal appeals court.[74] On the heels of that decision, three major malpractice insurers in Virginia restricted coverage for obstetricians and Virginia physicians soon began restricting obstetric services, with the largest impact in rural areas. (Virginia Code Sections 38.2-5000 to 5021)

- The **FLORIDA** law, passed during a special session in 1988, was an effort to hold down malpractice premium costs for obstetricians[75] (Florida Statutes Sections 766.301 to .316).

- Governor Mario Cuomo's **NEW YORK** no-fault plan for birth-related injuries is less limited than those in Virginia and Florida. The measure also would require obstetricians, gynecologists and pediatricians to become relicensed every seven years (and every three years if they are age 70 or older). According to the Intergovernmental Health Policy Project at George Washington University, the catalyst for support for the bill was the Harvard Medical Practice Study.[76]

- A **NORTH CAROLINA** bill (HR 546) would create a trust fund to pay the needs of children with birth-related cerebral palsy. The bill would also require obstetrician gynecologists to participate in local county health care plans to ensure care for indigent pregnant women. The bill would prohibit individuals from suing physicians or hospitals in birth-related cerebral palsy cases (but the state would keep the right to sue physicians for willful, malicious or wanton birth-related injuries).

- The **NATIONAL VACCINE INJURY COMPENSATION PROGRAM** allows families of children injured by vaccines to file for compensation with the program's claims court. Neither the manufacturer nor the physician are parties to the proceeding; compensation is provided

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[74]*Boyd et al. v. Bulala* (647 F. Supp. 781). The $8.3 million jury award exceeded the legislative cap of $750,000 on medical malpractice actions. The court found that the legislature may not "mandate the amount of judgment to be entered in a trial," and that legislative action to ease a crisis of the moment cannot prevail over the constitutional right to a trial by jury. The federal district court held that the state statute violated the patient's right to a jury trial.

[75]*Florida Medical Malpractice Reform and A Review of Court-Ordered Arbitration*, the staff of the Florida Senate Committee on Commerce, January 1988, p. 113.

[76]"Medical Malpractice: An Overview of 1991 State Legislative Activity," Intergovernmental Health Policy Project, the George Washington University.

> through a trust fund funded by an excise tax on covered vaccines. Families must first apply for compensation through the vaccine program. If they reject the offered award, they may pursue a claim through the tort system. The system is working for claims for injuries since the program began, but there are funding problems for the backlog of claims that occurred prior to October 1988.[77]

The Southern Regional Project on Infant Mortality reports that as of December 1991, no families have received compensation from the Virginia system and fewer than ten have been compensated from the Florida system. Actuaries had predicted about 40 claims per year in Virginia. In fact, 2 claims were filed in that state last year. One was dismissed because the providers did not participate in the program; the other is pending.[78]

Who May Benefit

To be eligible for compensation, an infant must have suffered a birth-related neurological injury and the attending physician must be a participant in the plan. Deaths are not compensated, nor are disabilities resulting from congenital or genetic abnormalities.

- Virginia defines birth-related injury as "injury to the brain or spinal cord of an infant caused by the deprivation of oxygen or mechanical injury occurring in the course of labor, delivery or resuscitation in the immediate post-delivery period in a hospital which renders the infant permanently nonambulatory, aphasic, incontinent *and* in need of assistance in all phases of daily living" (emphasis added).
- The Florida statute uses much the same language, but specifies that the infant must be of "term gestation" and that the injury can not be caused by "genetic or congenital abnormality."
- The New York proposal would allow any neurological injury sustained during pregnancy or the first 72 hours after birth, ranging from broken bones to cerebral palsy.

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[77] "Medical Liability and Access to Obstetrical Care: Can Alternatives to the Tort System Work?" Southern Regional Project on Infant Mortality, Washington, D.C., December 1991, p. 25.

[78] "Medical Liability and Access to Obstetrical Care," op. cit., p. 25.

Funding

In both Virginia and Florida, the plans are funded by fees levied on participating physicians and hospitals ($5,000 per participating physician annually plus $250 annually for all nonparticipating physicians; $50 per delivery with a $150,000 cap for participating hospitals). If the fund runs low on money, all liability insurers licensed to sell insurance in the state must contribute (with a cap of one-quarter of one percent of net premiums written). Florida further authorizes up to $20 million from the Insurance Commissioner's Regulatory Trust Fund.

The Intergovernmental Health Policy Project reports that a recent actuarial report concludes that the Florida plan may be collecting only half of what it needs to continue the fund. By the end of 1991, 11 claims had been filed, 6 of which were declared compensable. The other 5 were still under review when the project report was published. The Florida statute provides that if approved claims ever exceed 80 percent of the fund's reserves, the program is automatically closed against additional claims until the legislature acts. The policy project reports that claims filed in the interim would go through the traditional tort system and "that, according to some observers, is just what some attorneys are waiting for." The project says some lawyers are purposely delaying the filing of a claim in hopes that the fund will close down, since they stand to gain higher fees through the tort system than through the association.[79]

The Mechanics of the Plans

In both Florida and Virginia, the agency handling the state's workers' compensation claims (the Industrial Commission of Virginia; the Division of Workers Compensation in Florida) also handles birth-related claims. Workers' compensation agencies were chosen for the task because they have experience in deciding medical issues and awarding damages.

The family of an injured infant submits a petition, plus medical records, documents of incurred expenses and an estimate of future costs. The agency evaluates the claim to determine if child meets the criteria for compensation:

- Did the injury occur in a participating hospital?
- Does the attending physician participate in the fund?
- Did the injury render the infant permanently nonambulatory, aphasic, incontinent and in need of assistance in all phases of daily living?

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[79] "Medical Malpractice: An Overview of 1991 State Legislative Activity," Intergovernmental Health Policy Project, George Washington University.

- Was the suit brought within the statute of limitations (ten years in Virginia, seven years in Florida)?

In both Florida and Virginia, three physicians[80] review the case and submit a non-binding report to the workers' compensation agency. The agency (in Virginia) or deputy commissioner (in Florida) determines awardable compensation. Compensation is limited to net economic losses, plus loss of earnings from age 18 (in Virginia), plus reasonable attorneys' fees. The commission's determination can be appealed to the full commission (in Virginia), thence to the state appeals court.

The commission also sends the petition to the state board of medicine and the state department of health, with a request that the agency determine whether negligence on the part of the physician or hospital contributed to injuries. If either agency suspects negligence, the agency is to take appropriate action against the physician or the hospital.

In both states, the patient who uses this program cannot pursue any other remedies for the injury, with the exception of clear and convincing evidence that the physician or hospital "intentionally or willfully" caused the injury (in Virginia) or caused the injury with "bad faith, or willful and wanton disregard" (in Florida). The suit must be filed prior to, and in lieu of, any payment from the fund.

PRO: Advocates say the plan takes decisions away from lay jurors and places them in the hands of experts; that it compensates promptly; that it compensates only actual medical expenses, excluding collateral sources; that it eliminates pain and suffering and other punitive damages; and that it eliminates contingency fees.

CON: Critics say the plan is too expensive; that it does not hold the negligent practitioner accountable; that it subsidizes obstetricians; and that--without clear and convincing evidence of intentional, willful or wanton injury--the plan violates the constitutional rights of infants injured by participating physicians.

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[80] In Virginia, the physicians are selected through a plan developed by the state's medical schools; in Florida, they are a neurosurgeon, an obstetrician and a pediatrician.

SUBSIDIES AND SIMILAR DEVICES

Among subsidies are plans that help pay malpractice premiums and plans that help pay settlements or verdicts against certain physicians. In general, subsidies are intended to encourage physicians to practice in underserved geographical areas or specialties.

The subsidy proposals we reviewed do not appear to link eligibility for a subsidy to a physician's income.

Subsidizing Liability Insurance

A malpractice insurance subsidy can take several forms. The subsidy can be the difference between premiums with and without a specialty (e.g. obstetrics), perhaps up to a cap; it can be a specific amount of money; or it can be a percentage of the premium. One state (**ARIZONA**) uses money from the general fund. Another (**WEST VIRGINIA**) asks participating doctors to pay into the subsidy fund. A third (**TENNESSEE**) funds the program with proceeds from the sale of abandoned property.

- **NORTH CAROLINA'S** Rural Obstetrical Care Incentive (ROCI) subsidizes insurance premiums for obstetricians in rural areas. Under the law, the state transfers money to local health departments who ask to take part in the program. Physicians contract with the health department which pays part of the physician's premium (the difference between premiums with and without obstetric coverage to $1 million, or $6,500, whichever is less). For nurse midwives, the department pays $3,000 or the full cost of the premium, whichever is less. The mechanism is intended to help states retain practitioners who are already practicing in rural or underserved areas. Representative Robert Hunter, who sponsored the bill, says the plan is stopping the flow of doctors out of rural North Carolina and has been instrumental in reducing the state's infant mortality rate.[81]

- In **MAINE**, a 1990 Rural Medical Access program provides an annual premium credit (the difference between premiums with and without obstetrics to a maximum of $10,000) to qualifying physicians. To be part of the program, a physician must have insurance, must take Medicaid patients, must deliver babies, and must practice in "underserved" areas at least half of the time. (Maine Revised Statutes 24-A.75)

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[81] "Medical Liability and Access to Obstetrical Care," op. cit., p. 34-35; and Dag Ryen, "Finding Fault, Finding Funds," *State Government News*, October 1991, pp. 9-10.

- **TENNESSEE** also provides premium subsidies for family practitioners who provide obstetrics in medically underserved areas (the difference in premiums with or without obstetrics). The Health Access Act, passed in 1989, created a special account. The account is maintained through the proceeds from the sale of abandoned property. (Tennessee Code 66-29-151)

- In 1989, the **ARIZONA** legislature appropriated general funds to help pay the malpractice premiums of rural physicians who carry their own liability coverage and who deliver infants at non-federal rural hospitals. It also specified financial assistance for family physicians who deliver babies as well as for obstetricians who deliver care in "underserved" areas. "Underserved" areas are areas in which at least half of births to residents occur elsewhere; where obstetric services are threatened; where no prenatal services exist; where obstetric "back-up" care is not available; or where the average number of prenatal visits is below the state average. (Arizona Session Laws 1989, Chapter 290; HB 2467)

- A **NEVADA** law authorizes the University of Nevada School of Medicine to subsidize part of the malpractice insurance of prenatal care providers in eligible counties or communities. Eligible communities include those with one or more of the following: a provider of prenatal care does not offer services; half or more of live births to women who are residents of the county occur outside the county; the percentage of live births to women who received no prenatal care exceeds the statewide percentage; or the percentage of live births of babies with low birthweight is higher than the statewide percentage. Subsidies are limited to the difference between the cost of malpractice insurance with obstetrics and the cost without it. The provider must agree to provide prenatal care despite the woman's ability to pay. (Nevada Revised Statutes 442.1192)

- **In NEW YORK,** an obstetric and pediatric practitioner incentive demonstration program subsidizes medical liability premiums for practitioners who treat medically needy women and children up to one year of age (SB 6370, Chapter 266, 1991 Laws).

- A **WEST VIRGINIA** law provides malpractice insurance for participating physicians who provide obstetric treatment to Medicaid patients. The insurance covers claims, and is to be no less than $1 million for each occurrence (doctors may purchase excess coverage up to $3 million). Participating physicians pay the fund a premium for each Medicaid delivery. Premiums go into

an obstetrical/gynecological liability pool administered by the state board of risk and insurance management. (West Virginia Code 29-12-5)

- **ALABAMA** law directs the state Medicaid agency to provide increased financing for family practitioners, pediatricians and obstetricians to increase the availability of obstetrical services and address the difference in existing liability insurance premiums and the amount required for obstetrical practice (HB 497, Act. 596, 1991).

TEXAS, and **NORTH CAROLINA** also have malpractice premium subsidies, according to the American College of Obstetricians and Gynecologists State Legislative Fact Sheet, September 1991.

State Indemnification of the Physician

Some states pay at least part of settlements or verdicts for certain kinds of care. For example, some states cover the physician who treats Medicaid women and children, some cover the physician for care of patients referred by public health workers and some cover the physician who devotes a certain percent of a practice to treating the poor.

- In **MISSOURI**, the state's Legal Expense Fund (a self-insurance fund covering liabilities of state employees) was expanded to cover certain obstetrical care. It covers liabilities if the physician provides public health services without compensation or with minimal compensation to patients for medical care caused by pregnancy, delivery and child care under contract or employment with a city or county health department. The fund, which also covers other workers, pays malpractice claims by Medicaid patients. To be eligible the physician must be licensed; must agree to provide pregnancy, prenatal and child care services; and must agree to provide a written account of the circumstances surrounding any medical malpractice litigation, settlement or judgment plus any adverse disciplinary proceeding. This relieves physicians from having to buy insurance to cover the long "tail" of 20 years allowed by the statute of limitations for suits related to a birth injury, for these state-covered cases. The law was intended to reduce the cost of obstetric insurance premiums, but only one carrier has reduced these costs, according to the Southern Regional Project on Infant Mortality. (Missouri Revised Statutes 105.711)

- In **MONTGOMERY COUNTY, MARYLAND**, obstetricians become part-time county employees and are covered by the county's liability insurance when they treat patients referred by the county. The

physicians are covered by their own insurance when they treat private patients.[82]

- In TEXAS, a state Liability for Indemnification of Health Care Professionals law targets providers who deliver at least 10 percent of their care to indigent populations. Under the law, the state pays up to $100,000 for medical malpractice damages arising out of prenatal care, care during labor and delivery and care given to a mother or infant during the 30-day period immediately after delivery. For any other eligible medical malpractice claim, the state is liable for $25,000 for a single occurrence. (Texas Codes Annotated, Civil Practice and Remedies Code, Chapter 110)

- The LOUISIANA Health Care Access Act of 1990 creates a similar indemnity pool for practitioners who provide at least 10 percent of their care as charity care under Medicaid or under contract with public health centers or federal health centers. The Louisiana statute protects physicians only for the charity portion of their patient population. The state covers the first $100,000 of a judgment made as a result of prenatal care, care during delivery and post natal care for 30 days after delivery. Coverage for all other medical malpractice claims is limited to the first $25,000. The Louisiana law also provides for discounted liability premiums for physicians who devote at least 10 percent of their practice to charity care. (Louisiana Revised Statutes 40:1299.153)

FLORIDA, MISSISSIPPI, NORTH CAROLINA, OKLAHOMA and WEST VIRGINIA also provide state indemnification, according to the American College of Obstetricians and Gynecologists Legislative Fact Sheet.

PRACTICE PARAMETERS

Practice guidelines are standardized specifications for appropriate measures to take in the diagnosis and treatment of disease. They are intended to improve the outcome of medical care and to make medicine more cost-effective by eliminating unnecessary procedures.

Guidelines might be in the form of rules (algorithms or formulas, perhaps). At least two states have included practice parameters in legislation:

- FLORIDA law requires the state health department to establish practice parameters to be followed by physicians performing caesarean section deliveries when those deliveries are paid in

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[82] "Md. County Pays Obstetricians' Malpractice Premiums," *HealthWeek*, November 26, 1988, p. 15.

full or in part with state funds or federal funds administered by the state.

- About 15 percent of MAINE'S physicians have enrolled in a project which allows them to use as an affirmative defense in malpractice litigation the fact that they followed certain practice guidelines. The Maine statute does not allow guidelines to be used to establish negligence: "Only the physician or the physician's employer may introduce into evidence as an affirmative defense the existence of the practice parameters . . . " (Maine Public Laws Ch. 931 Section 2975 (1). The five-year project targets doctors in four areas: anesthesiology, emergency medicine, obstetrics and gynecology, and radiology. The program was authorized by the state legislature in 1990.[83]

Commentators expect judges to integrate practice guidelines into the decision-making process. They also expect guidelines to be useful for determining negligence. They appear unlikely to generate much new litigation. One physician-lawyer says guidelines can be effective if they are voluntary and if they indicate that acceptable practice includes a variety of responses to a particular problem.

Critics belie e physicians will avoid guidelines out of fear that they will generate malpractice lawsuits. They say that because guidelines do not insulate the physician from liability, they will lull the practitioner into false security that everything has been done to meet the standard of care. Others say lawyers will use guidelines to bring litigation that otherwise might not have occurred.[84]

PATIENT COMPENSATION FUNDS

A patient compensation fund is used to help pay large settlements or verdicts against a health care provider. The purpose is to keep down the cost of malpractice premiums by making it unnecessary for certain providers to buy expensive, high-protection coverage.[85]

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[83]"Maine Moves to Reduce Liability Premiums," *State Legislatures*, March 1992, p. 8.

[84]Troyen Brennan, "Practice Guidelines and Malpractice Litigation: Collision or Cohesion?" *Journal of Health Politics, Policy and Law*, Spring 1991, pp. 67 - 83.

[85]Information for this section is from Eleanor D. Kinney and William P. Gronfein, "Indiana's Malpractice System: No-Fault by Accident?" *Law and Contemporary Problems*, Vol. 54, No. 1, Winter 1991, p. 169-193.

Among states with patient compensation funds are **INDIANA** and **LOUISIANA**, which set up funds in the midst of the 1975 insurance malaise. **TEXAS** has a recent variation.

- The **LOUISIANA** fund, which dates from 1975, holds the physician liable for the first $100,000, but covers judgments of up to $500,000 plus all medical expenses and trial costs. Member physicians contribute a flat fee based on specialty. (Louisiana Revised Statutes 22.1.8)

- The **INDIANA** fund, which dates from 1978, pays the part of settlements or verdicts that total more than $100,000. It is financed by a surcharge on a provider's malpractice insurance. To be eligible for a payment, the insurer or the uninsured provider must settle $100,000 of a claim.[86] (Indiana Statutes 16-9.5)

- The **TEXAS** legislature in 1990 created a variation on this theme, (discussed in more detail in the section titled "Subsidies and Similar Devices). The Texas law allows the state to contribute the first $100,000 in damages awarded as a result of prenatal or neonatal care (only for obstetricians with a caseload of at least 10 percent charity care).[87] (Vernon's Texas Statutes and Code 5.15-4)

This section of the report discusses the Indiana concept in detail.

Indiana's Patient's Compensation Fund

Administrators of the Indiana Patient's Compensation Fund report that the great majority of claims large enough to be eligible for the fund were settled (21 out of 410 between 1975 and 1988). The average settlement involved major permanent or total disability. About 15 percent of the claims involved injuries to infants at birth, while about 30 percent were wrongful death cases.

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[86]Until 1985, one defendant had to contribute $100,000, part of which could be paid in the future, before a case was eligible for the fund. Since 1985, however, at least $75,000 must be paid at settlement, with a commitment to a future payment of $25,000. Further, more than one insurer can contribute to the $100,000 that makes the claim eligible for the fund. (Indiana Statutes 16-9.5-2-2.2 and 16-9.5-4-3)

[87]Dag Ryen, "Finding Fault, Finding Funds," *State Government News*, October 1991, p. 9-10.

Funding

The fund has wobbled on the edge of insolvency since it was created; a transfer payment from the state's Medical Malpractice Joint Underwriting Commission rescued it in 1984. The surcharge on providers which supports the fund was 10 percent of malpractice premiums from 1975 through 1982, but by 1988 the surcharge had increased to 125 percent and today it is 150 percent (*State Health Notes*, November 4, 1991, p. 3).

No-Fault by Accident?

Two Indiana University School of Law professors find persuasive evidence that the fund creates an incentive for insurers to behave as if Indiana had a no-fault system. Eleanor Kinney and William Gronfein point out that fewer Indiana claims are paid between $25,000 and $100,000 and more are paid at $100,000 (with, in 12 years, only 14 claims paid between $75,000 and $100,000). "Insurers are apparently willing to add a few dollars to get a claim to the PCF in order to terminate their obligation to defend the claim and pay related expenses," the professors say. As a result, "a state-run insurance fund is paying large sums of money to most PCF claimants without a formal determination of fault." Perhaps, muse the professors, this is "no fault by accident."[88]

They say the Indiana "no fault by accident" system offers intriguing opportunities for a new generation of reforms, such as designated compensable events (this scheme would identify a limited set of injuries, fix damages for each type of injury and award that amount to the patient). The patient's compensation fund already provides the structure for this kind of plan they say because it identifies the large claims that would be the most likely candidates for such a plan.

NO-FAULT PLANS

Under no-fault plans, patients' right to compensation would depend not on whether the doctor had been at fault, but on the fact that the injury had been caused by medical treatment. The purpose is to compensate all victims of medical injuries, not just those "lucky" enough to prove that their injuries resulted from negligence. The approach would spare doctor and patient the emotional and financial costs of a heated legal conflict.

No-fault proposals have made debuts in **ALASKA** and in **NEW YORK**.

- In 1989, **ALASKA** Governor Steve Cowper offered a no-fault plan in which patients would take claims to a board (the Alaska Health Care Claims Board), retaining the right of appeal to the state

[88] Eleanor Kinney and William Gronfein, *op. cit.*, p. 189.

superior court. In his letter of transmittal, the governor said the bill is an attempt to control the system of recovery "in this era of rising insurance costs, when doctors have been forced out of business." He called the bill an attempt to find a solution that will "lessen the burden on both sides of a claim." The bill is summarized later in this section (HB 345, SB 323 and sponsor substitute).

- In 1990, **NEW YORK** state health commissioner Dr. David Axelrod floated a well-publicized version of no-fault compensation (see, for example, the *New York Times*, January 25, 1990, page 1 and *Mac Neil/Lehrer Newshour*, February 28, 1990). The *New York Times* reports that New York obstetrician medical malpractice premiums in 1990 ranged from $40,000 in upstate New York to more than $100,000 on Long Island, making them second only to those of Florida.

How a Typical No-Fault Program Would Work

A generic no-fault insurance plan, proposed by Barry Manuel of Boston University School of Medicine (and described in the March 1, 1990 issue of the *New England Journal of Medicine)*, is similar to the workers' compensation program.[89] It is described below.

Administration

The Manuel no-fault plan would be administered by a nonprofit corporation governed by a board of directors, including physicians, insurers and consumers. Members would be appointed by the governor and approved by the legislature.

Definition of Medical Injury

Patients would receive compensation for medical injuries, defined as:

> "any illness, injury, impairment or death that was due to the act or failure to act or diagnose, of a health care provider during the course of a medical examination or intervention, and that was not within the reasonable range of medical outcomes that might occur as the result of a condition."

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[89]Analysts proposed no-fault solutions in the mid-1970s, calling them "medical adversity insurance," "hospital accident insurance," as well as "no-fault." The American Bar Association published a no-fault concept in 1979.

The board would publish a list of approved compensable medical injuries. Not included would be injuries caused by a defective drug or device used in a medical examination or intervention and injuries inflicted intentionally.

Filing Claims

Under Dr. Manuel's plan, physicians or hospitals would file claims on behalf of their patients. Lawyers would be allowed to represent patients, but their fees would be statutorily set (eliminating contingency fees). A board of physician-specialists would review all claims for which compensation might exceed $10,000. It would also investigate hospitals and physicians against whom repeated claims were made. Awards would cover net economic losses only, with no compensation for pain and suffering, mental anguish, punitive damages.

Default to the Tort System

Patients would have the right to decline awards and turn to the tort system for relief. Dr. Manuel believes patients would have several incentives to remain with the no-fault system. He says patients traditionally have poor success against physicians in court; they would lose up to half of the award in attorneys' fees and expenses; and they might have to wait years to settle the claim.

Under the plan, the board could work in cooperation with the state to arrange for disciplinary action or retraining. If a hospital were found to be substandard, the board could work with the state and the Joint Commission on Accreditation of Healthcare Organizations to correct problems.

Funding a No-Fault Program

Dr. Manuel suggests paying for the plan with a surcharge on every health and accident insurance policy sold. He says that, nationwide, a surcharge of $60 on every private major medical policy would have yielded more than twice the amount of money collected from physician medical malpractice premiums in 1987. He says that reduced overhead and excessive awards would leave more money to compensate injured patients. Although physicians would still need liability insurance for cases not covered under the no-fault system, the coverage would be a small fraction of what it is today and, further, the cost of defensive medicine would go down.

Dr. Manuel says a review of 100 closed claims in Kentucky (comparing cost of claims under the current tort system with cost under a proposed no-fault system) showed a savings of almost one-half, with injured patients receiving more net benefits than they receive under the current system.

One actuary estimates that a no-fault approach could yield overall savings in the range of 20 to 25 percent of total medical costs. He says no-fault insurance should reduce the cost of premiums by reducing charges for defensive procedures. Among the nonmonetary benefits would be "the return of those obstetricians who had ceased to serve when insurance costs and liability overburdened them. (*Contingencies* January/February 1991, p. 52)

Alaska's No-Fault Proposal

Governor Cowper's no-fault bill (HB 345 or SB 323) was introduced in May 1989.

The Board

The bill proposed an Alaska Health Care Claims Board of five people (a lawyer, a health care provider and three others who are not, and have not been, connected with the medical or legal professions). Members would be appointed by the governor, serving staggered four-year terms. The board, which would be under the state Department of Commerce and Economic Development, would have the power to adopt regulations and subpoena witnesses.

The Process

A patient could take a claim to the board after it was denied by the health care provider. The board would accept all claims, except those which it determined violated the act or were unfair. The board would be required to hold a hearing within 90 days of a request by the patient or provider. The board must come to a decision within 30 days after the record closes and the decision must be easy to understand and supported by reasoned conclusions.

Compensation

The board would decide whether to order compensation in three basic categories: temporary impairment, permanent impairment and death. The patient may recover for medical expenses, treatment and lost wages for existing employment at the time of the injury. Compensation would not include pain and suffering but the board could assess $1 million for injury caused by a prover's use of drugs or alcohol or by a provider's deliberate and malicious act or conscious disregard and reckless indifference. A party would have the right to appeal to superior court.

Medical expenses would be paid within 30 days; compensation for permanent impairment would be paid in a lump sum; lost wages would be paid by the week. Deaths would be compensated by medical expenses, lost wages and $1 million to dependents. Damages would be reduced by the amount of collateral sources of payment.

The Bill's History

In the House of Representatives, the bill was referred to the Labor and Commerce, Judiciary and Finance committees. In the Senate, it was referred to Judiciary, Labor and Commerce and Finance. The bill remained in the first committees of referral.

PRO: Advocates contend that a no-fault approach eliminates the costly and inefficient need to establish fault in an adversarial system. Compensation would be fair and timely; the negative effects of defensive medicine (costs and tests) would go down; and the public and the medical profession would have comprehensive information about poor results and errors in medical practice. The Harvard Medical Practice Study argues that a no-fault program would build quality into the medical care system by holding the system liable for a broader range of injuries. It would create a financial incentive within that system for safer care and better prevention of future injuries to all patients. The study authors contend that the no-fault plan functions as a deterrent because, just as under the current system, it holds doctors and hospitals responsible for fault-caused injuries.[90]

CON: Critics say that, practically speaking, it is impossible to pass legislation that takes income away from a major segment of the legal profession (*Contingencies*, January February 1991); that no-fault plans do not deter because they do not assign blame for specific negligent acts; and that they are too expensive because they would open compensation to more people.[91] Ralph Nader objects that no-fault systems prohibit compensation for pain and suffering; do not disclose defect information; do not deter harmful behavior; and do not produce

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[90]Harvard Medical Practice Study, *Patients, Doctors and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York*, Harvard College, 1990, p. 2-13.

[91]Critics who use the Harvard Medical Practice Study to back up this assertion unintentionally mischaracterize the study. They say the study shows that only one of every eight people injured by medical care files suit. What the report actually says is that eight times as many patients are injured by medical care as file a malpractice claim. (See, for example, Phillips and Kalb in "Replacing the Tort System for Medical Malpractice, *Stanford Law and Policy Review*, Fall 1991, p. 210-215; Ralph Nader and Joan Claybrook in "Preserving a Pillar of Our Democracy," *Trial*, December 1991, pp. 45-49; and Robert MacNeil, in introductory remarks to a newscast featuring New York's Dr. David Axelrod, Wednesday Feb. 28, 1990.)